County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

425 Shatto Place, Los Angeles, California 90020
(213) 351-5602

PHILIP L. BROWNING
Director

May 15, 2013

To: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Gloria Molina
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: Philip L. Browning
Director

RESPONSE TO THE OCTOBER 11, 2011 AND FURTHER AMENDED ON NOVEMBER 3, 2010 MOTION COMPILING LOS ANGELES COUNTY DATA ON CHILD ABUSE, NEGLECT AND DEATHS

In response to the above motion, we have provided reports dated November 10, 2011, February 21, 2012, May 22, 2012 and October 1, 2012.

On December 8, 2012, on motion of Supervisors Mark Ridley-Thomas and Michael Antonovich directed the Chief Executive Officer, in consultation with the Directors of the Department of Children and Family Services, Health Services and Public Health, the Office of the Coroner, and County Counsel to report back within 45 days and identify:

- An existing County entity to serve as the responsible entity for compiling data related to child safety indicators. The proposed entity shall also be responsible for collecting and periodically reporting aggregate data on those indicators to the Board of Supervisors in a manner that protects the confidentiality of the child, aligns with the Board's direct oversight of the Department of Children and Family Services and informs future policy development.
- A proposed standardized countywide protocol for reporting key child safety factors.
- Ten to fifteen proposed key child wellness indicators on which Los Angeles County departments should uniformly report that would best enable the Board of Supervisors to discern trends and adopt responsive preventive polices that promote increased child safety and wellness, especially among infants.
- A proposed timeline, staffing model, and reporting schedule.

The Chief Executive Office (CEO) received an extension to respond to the Board motion, now due July 31, 2013 and continues to work with various agencies in response to the motion. In the interim, DCFS along with ICAN and the CEO continued to prepare an update to the October 1, 2012 report.

In our October 2012 report, we indicated that we worked with the Los Angeles County Department of Public Health (DPH), Office of Health Assessment & Epidemiology, the Pasadena Public Health Department-Office of Vital records, and the City of Long Beach Public Health Department to obtain their data and reconcile against DCFS databases in order to obtain the most comprehensive data on child deaths. On January 29, 2013, we were informed by DPH that they could no longer provide data and advised DCFS to apply to the State to receive the data directly. We submitted the application and awaiting a response. As such, this report includes only the fatalities that were reported to the Department of Children and Family Services (DCFS) for 2012. 2011 data was updated and also used for comparative purposes.

Highlights

In 2012, there were 316 child deaths reported to DCFS while in 2011 there were 360 deaths reported; a decrease of 44 deaths between 2012 and 2011. Of the 316 2012 child deaths, 94 (30%) had contact with DCFS. Specifically, 24 (25%) had an Open DCFS Case at time of the fatality; 15 (16%) had an Open Referral; 15 (16%) had a Prior Case and 40 (43%) had a Prior Referral (see Attachment, page 17 for details).

We reviewed mode of death, cause of death, and circumstances for those deaths reported to DCFS in 2011 and 2012. Of the 360 deaths reported to DCFS in 2011, 82 were determined to be accidental, 58 natural, 19 suicides, 63 homicides and 107 were "undetermined." The variance between ICAN's reported data for 2011 and DCFS are addressed in the attachment of this report (see page 33).

We are in the process of reviewing 205 autopsies for 2012 and collecting data on the Coroner's cause and mode of death. We have reviewed 89 autopsies and of those, 37 were determined to be accidental, 12 were determined to be natural, eight were suicides, 16 were homicides and 16 were "undetermined."

With regard to homicides, there were 63 in 2011 and 16 in 2012, a decrease of 47. However, our review of 2012 fatalities continues. The number of homicides by mother decreased from four to two and by father from eight to zero. The number of homicides where the perpetrator was unknown decreased by 22 from 2011 to 2012. It should be noted the 2012 data will be impacted once the 205 autopsies have been reviewed.

We identified captured trends based on the review of the fatality circumstances as reported to DCFS via autopsy reports, fatality referrals, DCFS investigations and law enforcement findings. For purposes of this report, the captured trends have been categorized for each mode of death with the exception of "undetermined" mode as they require in-depth analysis. Our preliminary analysis for "undetermined" is similar to ICAN's in that trend for 2011, is co-sleeping, followed by unsafe sleeping environment deaths. Our analysis of 2012 continues however, we did identify a trend in co-sleeping and unsafe sleeping environment deaths. ICAN has a subgroup which conducts in-depth reviews on undertermined deaths and this group may be the best suited in further analysis. We are exploring the feasibility of this with ICAN.

New Developments

On December 28, 2012, the Court, in *Butterfield v. Lightbourne* invalidated the State regulation requiring that a child fatality be the result of abuse/neglect by a parent or guardian in order to meet the criteria for subdivision (c). As a result of the ruling it is no longer necessary for the abuse/neglect that led to the death to have been inflicted by a parent or guardian for a fatality to meet subdivision (c) criteria. The perpetrator can now include any person that inflicted the abuse that led to the child's death. This ruling has the potential to impact the number of fatalities that meet subdivision (c) and may in turn increase the number of cases released to the public upon DCFS receiving an SB 39 request. Child fatalities that may be subject to this ruling continue to be under analysis.

Next Steps

- We will follow up with the State regarding the status of the application to obtain child fatality data.
- DCFS and ICAN will work together in the coming months to integrate and report consistently on data where there are differences that reflect the historical methodology in conjunction with the Coroners and the (SB 39) methodology used by DCFS.
- DCFS will review the remaining 205 autopsy reports for 2012 and update data presented for 2011 and 2012 data.
- Our October 1, 2013 report will address the child deaths that occurred during the period January 1, 2013 through June 31, 2013 and will be reflective of DCFS and ICAN joint reconciliation of actual cases as opposed to data for each category and method of death.

If you have any questions, please call me or your staff may contact Aldo Marin, Manager DCFS Board Relations Section, at (213) 351-5530.

PB:BN
FL:ft

Attachments

c: Executive Office, Board of Supervisors
Chief Executive Officer
County Counsel
Interagency Council on Child Abuse and Neglect

Attachment

Child Fatality Aggregate Data
January 1, 2012 to December 31, 2012

Board Motion: Statement of Work

Board Motion by Mayor Michael D. Antonovich voted on October 11, 2011 moved that the Los Angeles County Board of Supervisors directs the Interim Director of Children and Family Services, in conjunction with the Chief Executive Officer and all affected agencies that partner in child welfare services, County Counsel and the Interagency Council on Child Abuse and Neglect, to report back in 30 days and quarterly thereafter on a mechanism by which to comprehensively report on child abuse, neglect and deaths in a meaningful way to inform the Board's child safety, permanency and self-sufficiency policy decisions.

Board Motion by Supervisor Mark Ridley-Thomas and Mayor Michael D. Antonovich, voted on October 12, 2010 and further amended on November 3, 2010 moved that the Chief Executive Officer (CEO), in consultation with the Department of Children and Family Services (DCFS) and County Counsel, compile vital LA County death statistics for the past ten years including but not limited to:

- **Total number of child deaths with DCFS history;**
- **Age, area of residence, and area of death location of the children;**
- **Cause of death and circumstances;**
- **Abuse or neglect status;**
- **Alleged perpetrator in homicides;**
- **DCFS status and placement at time of death;**
- **Race/ethnicity of the child; and**
- **Indication of whether one or both parents were minors at the time of the child's birth.**

Data Dictionary

Term	Definition
Accidental Death	Result from an unplanned and unforeseeable sequence of events.
Butterfield vs. Lightbourne	On December 28, 2012, the Court in *Butterfield v. Lightbourne* invalidated the State regulation criteria requiring that a child fatality be the result of abuse/neglect inflicted by a parent or guardian in order to come within subdivision (c). As a result of the Court's ruling, it is no longer necessary for the abuse to be inflicted by a parent or guardian and may include any person that inflicted abuse leading to a child's death.
Captured Trend	Based on a review of Fatality Circumstances as reported to DCFS via Autopsy Reports, Fatality Referrals, DCFS investigations, and law enforcement findings.
Family History	Sibling of the child had an open case or referral with DCFS at time of child's death or a closed case or referral prior to the child's date of death. Parent of the child had an open case or referral with DCFS at time of child's death or a closed case or referral prior to the child's date of death.
Foster Family Agency Certified Home	Home that is certified by a Foster Family Agency, a private agency. When a family is certified by a foster family agency (FFA), a social worker from that agency visits their home on a regular basis. Some foster family agencies are also licensed adoption agencies. In some cases a foster family agency social worker may also conduct the adoption home study.
Foster Family Home	Home in which 24-hour non-medical care and supervision are provided in a family setting in the licensee's family residence for not more than six foster children.
Group Home	A facility that provides 24-hour non-medical care and supervision to children. A facility that provides services to a specific client group and maintains a structured environment, with such services provided at least in part by staff employed by the licensee.
Guardian Home	Home of guardian who was empowered by a court to be the guardian of a minor.

Data Dictionary

Term	Definition
Homicide Death	Occur by the hand of someone other than the dead person.
ICAN	Inter-Agency Council on Child Abuse and Neglect. Their findings are based on Final Modes determined by the Coroner. ICAN data includes those deaths that are completed by LA County Coroner, and they do not include mode of deaths classified as natural and deaths that do not become Coroner's Cases.
In-Home	Home of Parent
Mode of Death	Is the root cause of the sequence of events that lead to death classified by the Coroner.
Natural Death	Are the workings of "Mother Nature" in that death results from a natural disease process.
Non-Foster Care	Hospitals, medical facilities, and psychiatric facilities that provide medical or mental services on an emergency basis.
Non-Relative Extended Family Member (NREFM) Home	Home of any adult caregiver who has established familial or mentoring relationship with the child. The parties may include relatives of the child, teachers, medical professionals, clergy, and neighbors and family friends.

Data Dictionary

Term	Definition
Relative Home	Home of a person connected to another by blood or marriage. It includes parent, stepparent, son, daughter, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin or any such person denoted by the prefix “grand” or “great” or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.
SB39	Senate Bill 39 (SB39) became effective on January 1, 2008, and applies to child deaths that occurred on that date, or thereafter. SB39 permits a member of the public to request certain information and records regarding child fatalities where there is a reasonable suspicion that the child’s death was caused by abuse or neglect, or where a determination is made that abuse or neglect led to a child’s death. In August 2010, the Board adopted the recommendations of the Office of Independent Review, which called for SB39 determinations to be made in favor of disclosure.
SB39 Sub-division A	Final determination concluded that the fatality met subdivision A criteria (Reasonable Suspicion that the fatality was caused by abuse and/or neglect).
SB39 Sub-division C	Final determination concluded that the fatality met both subdivision A & C criteria (the fatality is Confirmed to be caused by abuse and/or neglect) by either law enforcement, Coroner, or DCFS.
Small Family Home	Any residential facility in the licensee’s family residence providing 24 hour care for six or fewer children with a mental disorder, developmental disability, or physical handicap and who require special care and supervision as a result of such disabilities.
Suicide Death	Are caused by the dead person’s own hand.
Undetermined Death	Occur when the Coroner cannot accurately determine the appropriate category.

2012 : Working Assumptions & Data Limitations

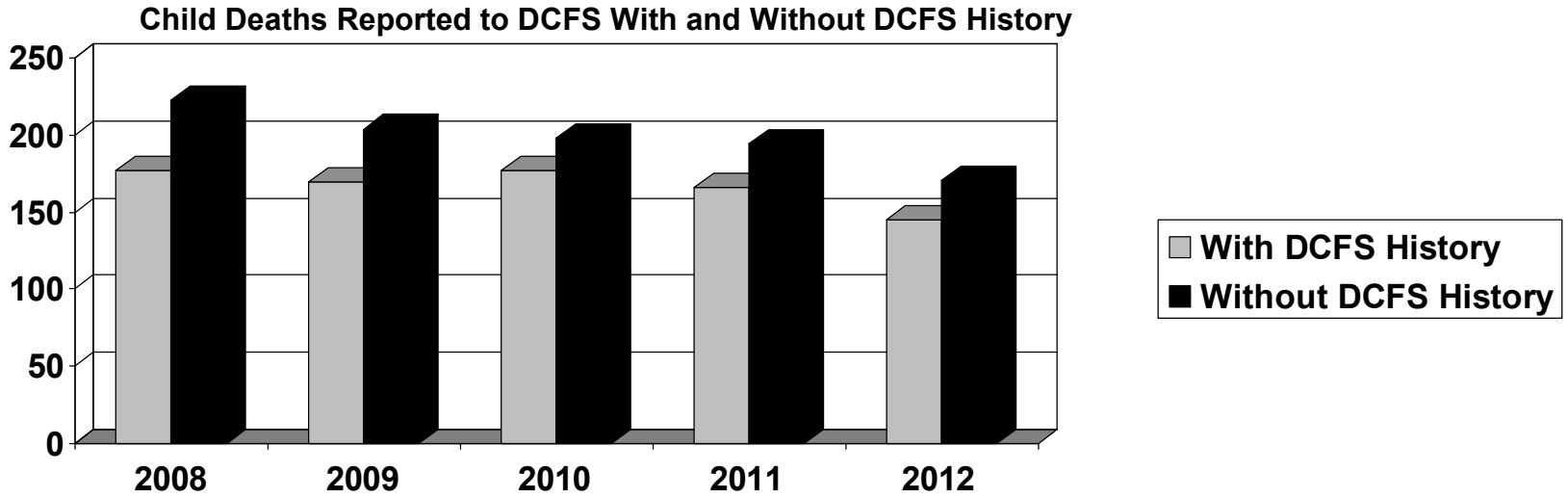
- Child death population includes ages 0-17 with and without DCFS history and 18-21 with an open DCFS case upon date of death. Child deaths reported to DCFS and meet jurisdictional criteria:
  - Death occurs within LA County and child is a resident
  - Death occurs within LA County and child resides in another county and there is no open referral or case in a child welfare agency outside of LA County
  - Death occurs outside LA County and there is an open DCFS referral or case within LA County
- Child deaths were determined to have DCFS history if they met one of the following criteria:
  - Child had an open case or referral at time of death or a closed case or referral prior to the date of death
  - Sibling of the child had an open case or referral at time of death or a closed case or referral prior to the date of death
  - Parent of the child had a closed case or referral prior to the date of death
- For comparative purposes, statistics on children receiving services from DCFS and general child population statistics for LA County is provided where applicable.
- In order to provide a more current and comprehensive view of child fatalities with and without DCFS history for CY 2012, additional validation and analysis was conducted, specifically analysis of captured trends and homicides. As such, validated data for CY 2011 is also provided for all data elements available.
- SB39 determinations are based on investigative results from DCFS, law enforcement, and Coroner. Not all deaths classified as homicide by Coroner meet SB39 criteria. Prior to January 9, 2013 *(Butterfield vs. Lightbourne),* SB39 criteria was met when the child's death was a result of parental/caregiver abuse/neglect.
- Child fatalities (2012) that may be subject to *Butterfield vs. Lightbourne* are still under analysis.
- Captured Trend: 1.) DCFS determines captured trends by reviewing final autopsy report and fatality circumstances. Some captured trends are deemed preliminary pending final autopsy. 2.) On those cases that are "Not a Coroner's Case" captured trends are based on reported fatality circumstances. Captured Trends are open to interpretation.

2011: Data Elements & Data Source

Data Elements Requested	Data Source
1.Total # of child deaths with and without DCFS History	CIFT*
2.Age of Child	CWS/CMS
3.Gender	CWS/CMS
4.Race or Ethnicity	CWS/CMS
5.SB39 Categorization	CIFT*
6.Area of Residence	CWS/CMS
7.Incident Location	CIFT*
8.Captured Trends: Death Circumstances	CIFT*
9.Cause of Death	CIFT*
10.Mode of Death	CIFT*
11.Alleged Perpetrator in Homicides	CIFT*
12.DCFS Status at Time of Death	CIFT*
13.Placement at Time of Death (Open Cases)	CWS/CMS
14.Were parents minors at child's birth	CWS/CMS
15.Were parents minors at child's death	CWS/CMS
16.Did parents have a DCFS referral as a minor	CIFT*
17.Family with at least one open case or referral 10 months prior to deceased child's date of birth	CWS/CMS
18.Minor parents with open case at deceased child's date of death	CWS/CMS

*The Critical Incident and Fatality Tracking (CIFT) is a web-based system that was designed to capture all of the pertinent data elements that are not currently being captured in the CWS/CMS database. The system tracks and maintains comprehensive and pertinent data elements needed to report child fatalities, critical incidents, near fatalities and SB 39 related deaths that resulted from child abuse and/or neglect.

Aggregate and Trend Data on Child Deaths 2008-2012



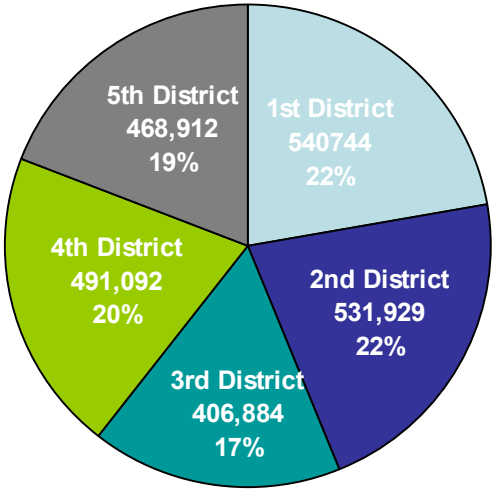
DCFS History	2008	2009	2010	2011	2012
With Prior DCFS History	177	170	177	166	145
Without Prior DCFS History	223	204	198	194	171
Total	**400**	**374**	**375**	**360**	**316**

2012 - Summary of Data Findings for 145 Fatalities With DCFS History

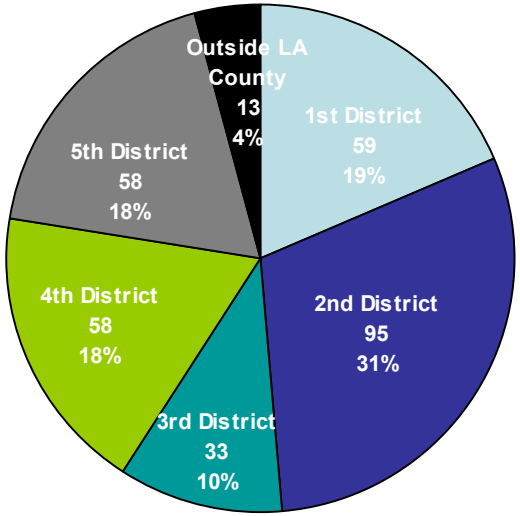
- **Highest number of child deaths by:**
  - Race/Ethnicity: Hispanic/Latino (50%), African American (35%), and White (10%)
  - Gender: Male (58%), Female (41%), Unknown (1%)
  - Age: 0-1 (33%), 12-17 (32%), 4-11 (16%), Prenatal (12%), 2-3 (6%), 18-21 (1%)
  - Supervisorial District by Incident: 2nd (41%), 1st (19%), 5th (15%), 4th (12%), 3rd (8%)
- **DCFS Status prior to or at time of death:**
  - 17% had an open case and 10% had an open referral
  - 38% had a closed case or referral (important to note that closed cases or referrals may span an entire lifetime)
  - 35% did not have DCFS history themselves but had a family member with DCFS history and the DCFS history could have occurred prior to the deceased child's birth
  - 26% of child deaths, mother and/or father had at least one open case or open referral 10 months prior to deceased child's date of birth
  - 6% had a minor parent at birth, 1% had a minor parent at death, and 0% had a parent with a DCFS referral as a minor
- **Placement at time of death for 24 open cases:**
  - 21% Non Foster Care
  - 4% Foster Family Agency Certified Home
  - 4% Foster Family Home
  - 4% Group Home
  - 4% Guardian Home
  - 8% Relative/NREFM Home
  - 55% In-Home placement at time of death

Contextual Statistics

2011 Child Census Population= 2,439,561



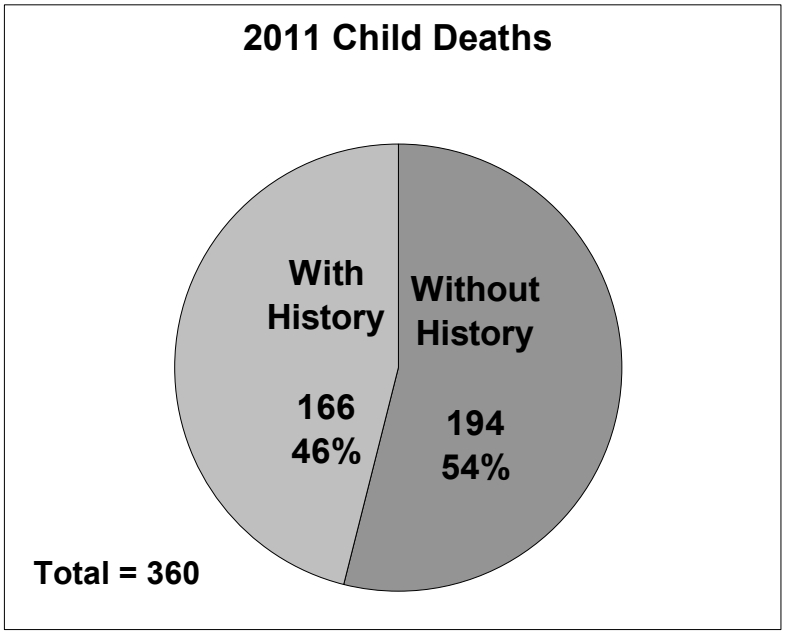
2012 Total DCFS Deaths = 316

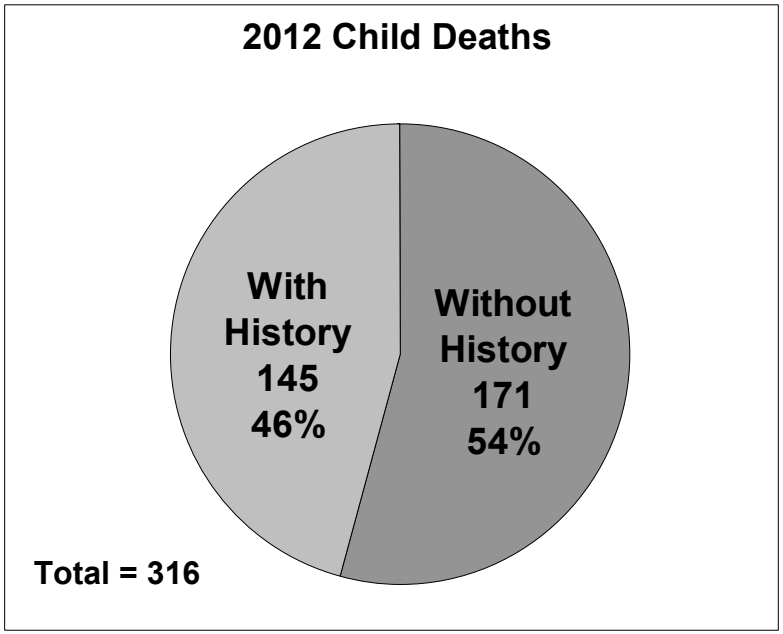


Explanation	Number
The number of children ages 0-17 living in LA County in CY 2011. *- Based on the Population Data from U.S. Census Bureau (census data used to conduct this analysis is not available for CY 2012, therefore we are using CY 2011data)*	2,439,561
The number of children referred to DCFS in CY 2012. This represents approximately 6% of the general population of children living in LA County. *Based on DCFS CWS/CMS Datamart Database*	157,868
The number of children with an open case in CY 2012. This represents approximately 2.36% of the general population of children living in LA County. *Based on CWS/CMS*	57,574
The number of open cases as of December 31, 2012. This number represents the approximate number of open cases DCFS is managing at a single point in time. *Based on CWS/CMS*	35,195
The number of child fatalities in CY 2012 with DCFS history, which roughly represents 25% of children with an open DCFS case or referral in CY 2011. *- Based on validated CY 2011 figures and refers to children with ANY DCFS history (including siblings' and parents') who died in CY 2011 and is not limited to children who had an open DCFS case in CY 2011*	145
SB39-The number of fatalities with and without DCFS history with a reasonable suspicion or determination that abuse/neglect led to the child's death in CY 2012. This number includes deaths where a determination was made that abuse/neglect lead to the child's death (SB39 Subdivision A, Butterfield, and A & C. Page 11).	46
SB39-The number of fatalities with DCFS history with a reasonable suspicion or determination that abuse/neglect led to the child's death in CY 2012. (SB39 Subdivision A and A & C. Page 11).	24

Comparative View
2011 vs. 2012 Child Deaths Reported to DCFS

There were 44 fewer deaths reported in 2012 as compared to 2011 and yet no change in the percentages of those child deaths reported to DCFS with and without history between 2011 and 2012





SB 39 Abuse and/or Neglect Comparative View 2011 vs. 2012

Deaths Reported to DCFS which met SB39 Sub-divisions	2011 With History	2011 Without History	2011 Totals	2012 With History	2012 Without History	2012 Totals
SB39 Sub-division A: Final determination concluded that the fatality only met subdivision A criteria (Reasonable Suspicion that the fatality was caused by abuse and /or neglect.	18	16	**36**	4	**2**	**6**
SB39 Sub-division A&C: Final determination concluded that the fatality met both subdivision A & C criteria (the fatality is Confirmed to be caused by abuse and/or neglect.)	19	21	**40[1]**	20	18	**38[1]**
SB39 Sub-division A&C- Butterfield:	N/A	N/A	**N/A**	0	2	**2**
Pending Final Determination*:	0	1	**1[2]**	78	102	**180***
Not SB39: DCFS, Law Enforcement, and Coroner investigations concluded that the child's death was not a result of abuse/neglect	129	156	**283**	43	47	**90**
Total	**166**	**194**	**360**	**145**	**171**	**316**

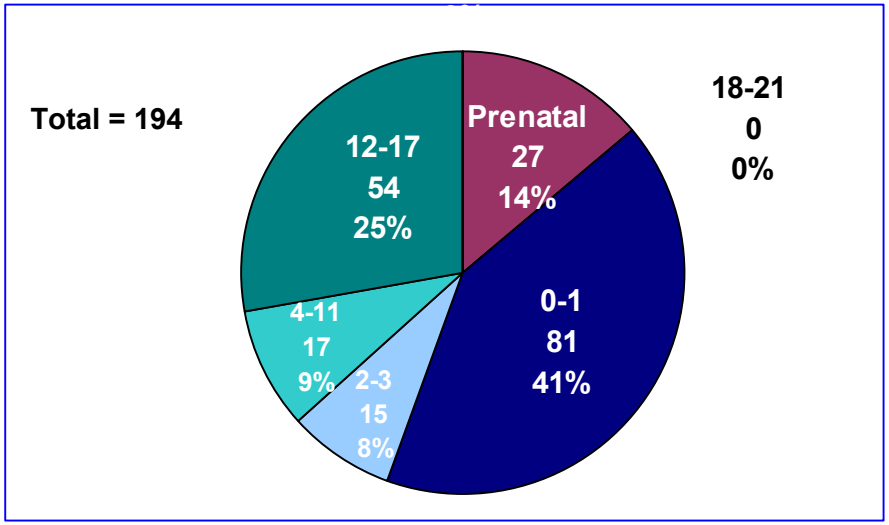
[1]There were 63 homicides in 2011 and 16 homicides in 2012 (see page 20), however, not all of those homicides met SB39 criteria. Third Party Homicides were excluded from SB39 criteria until January 9, 2013, when DCFS adopted guidelines based on Butterfield vs. Lightbourne.

[2]One case is on security hold by Law Enforcement and Autopsy Report will not be released.

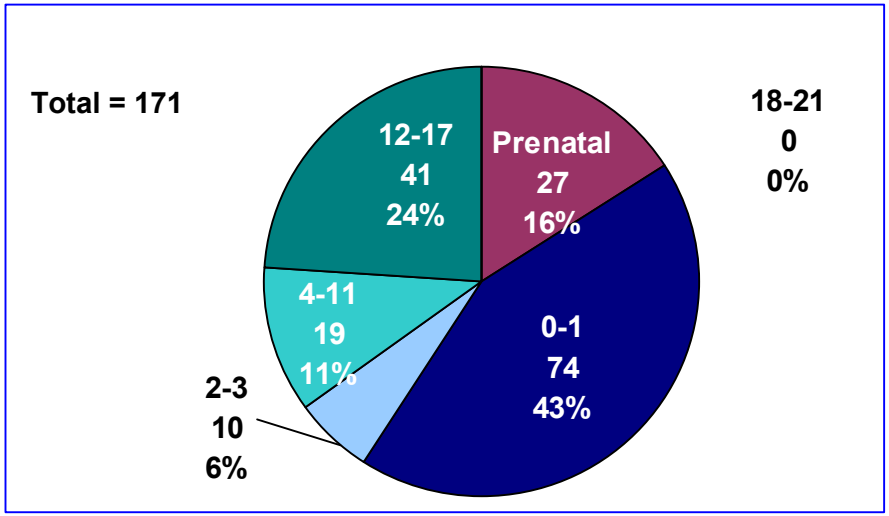
***Pending Final Determination: Pending investigative results from Law Enforcement and autopsy reports are currently under review by DCFS.**

Comparative View
Age of Child at Time of Death 2011 vs. 2012

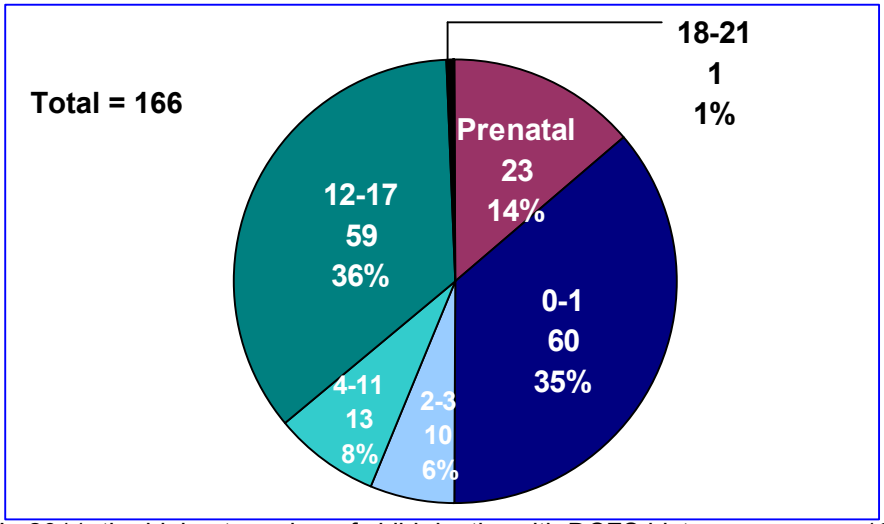
2011 Age of Child at Time of Death (Without DCFS History)



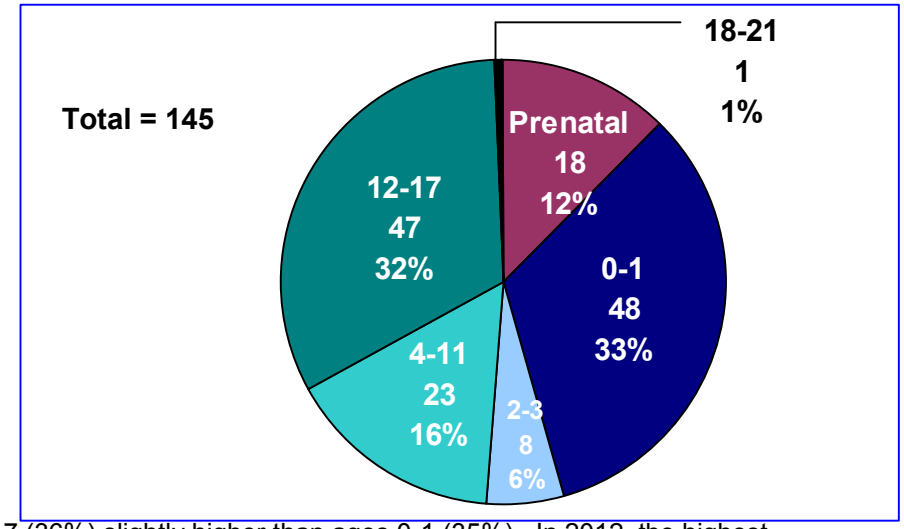
2012 Age of Child at Time of Death (Without DCFS History)



2011 Age of Child at Time of Death (With DCFS History)



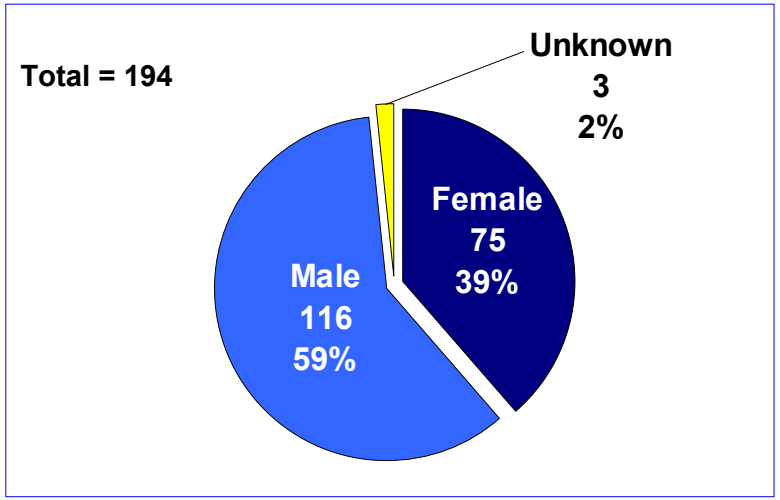
2012 Age of Child at Time of Death (With DCFS History)



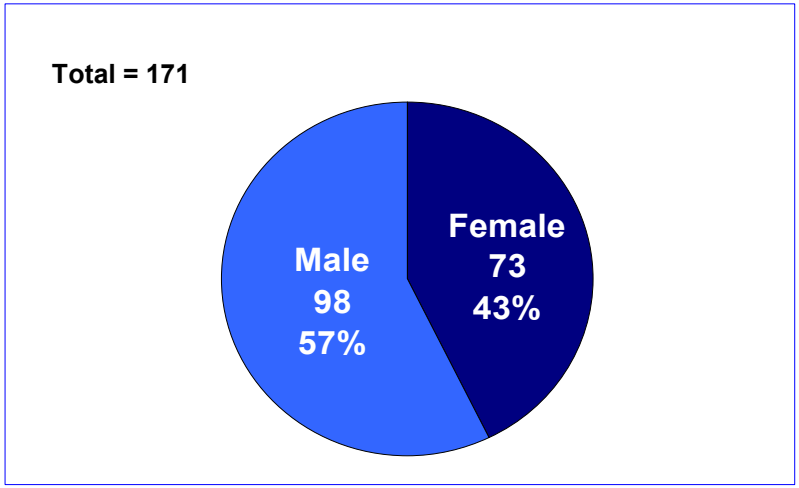
In 2011, the highest number of child deaths with DCFS history were ages 12-17 (36%) slightly higher than ages 0-1 (35%). In 2012, the highest number of child deaths were ages 0-1 (33%) slightly higher than ages 12-17 (32%). Note: CWS/CMS does not have an indicator for prenatal deaths. Therefore, prenatal deaths include children with the same birth date and death date.

Comparative View
2011 vs. 2012 Child Deaths Reported to DCFS by Gender

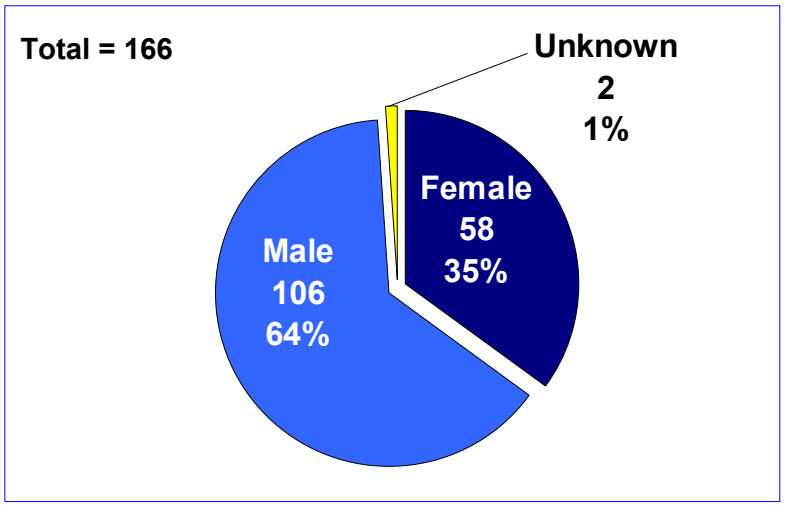
CY 2011 Child Gender (Without DCFS History)



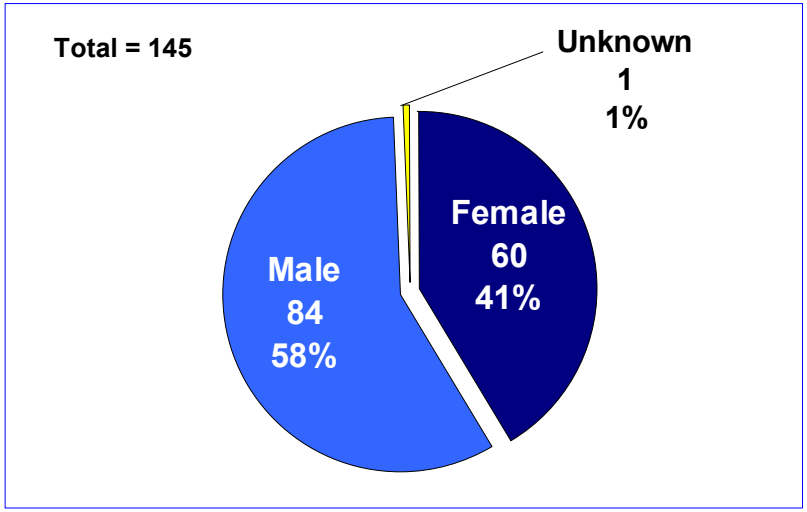
CY 2012 Child Gender (Without DCFS History)



CY 2011 Child Gender (With DCFS History)



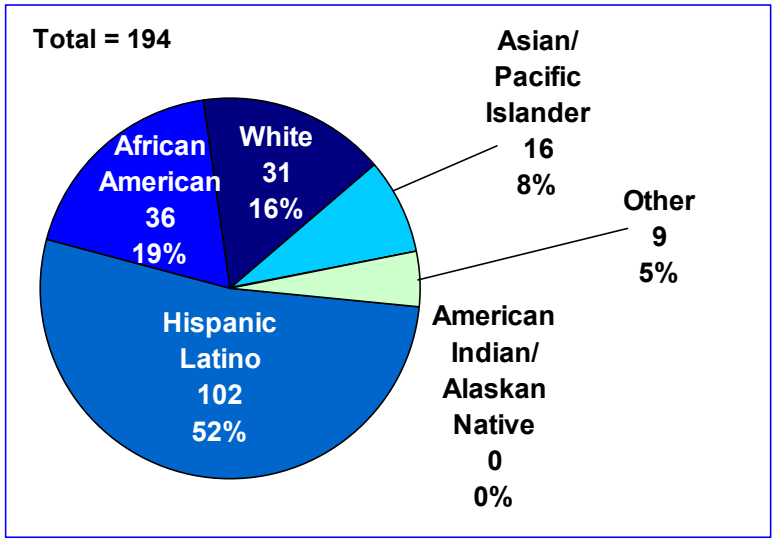
CY 2012 Child Gender (With DCFS History)



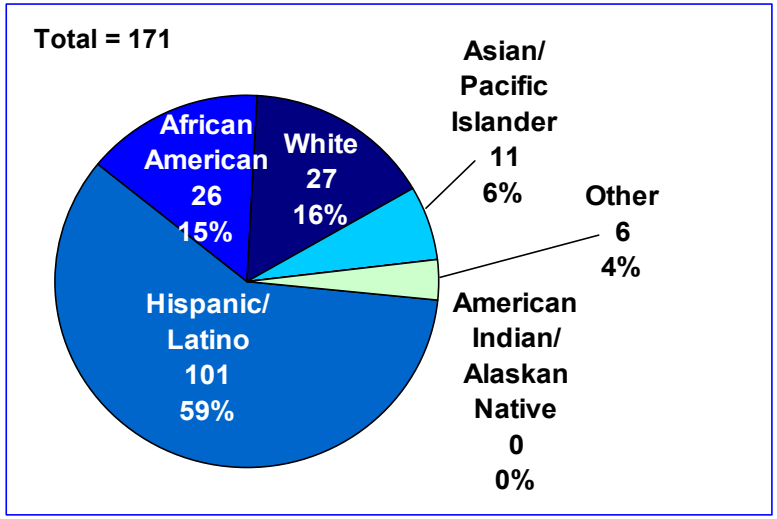
Note: Unknown = Gender's are unidentifiable as these child deaths are at gestational ages.

Comparative View
2011 vs. 2012 Child Deaths Reported to DCFS by Race/Ethnicity

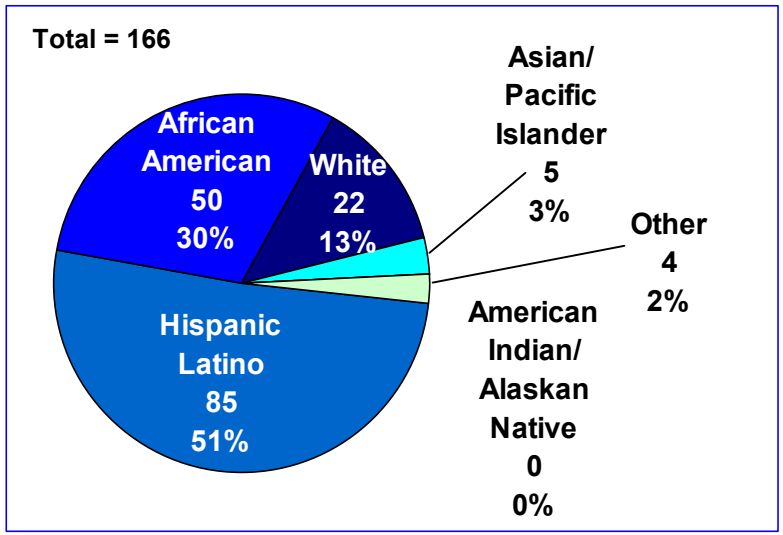
CY 2011 Child Race/Ethnicity (Without DCFS History)



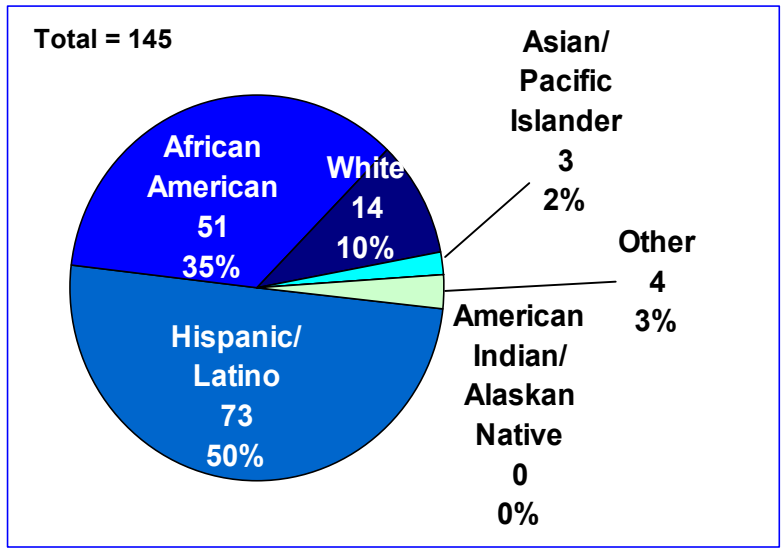
CY 2012 Child Race/Ethnicity (Without DCFS History)



CY 2011 Child Race/Ethnicity (With DCFS History)



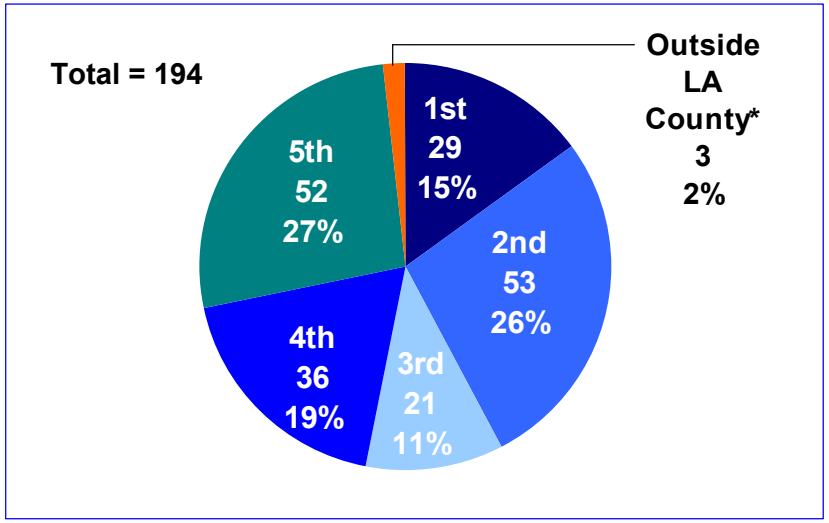
CY 2012 Child Race/Ethnicity (With DCFS History)



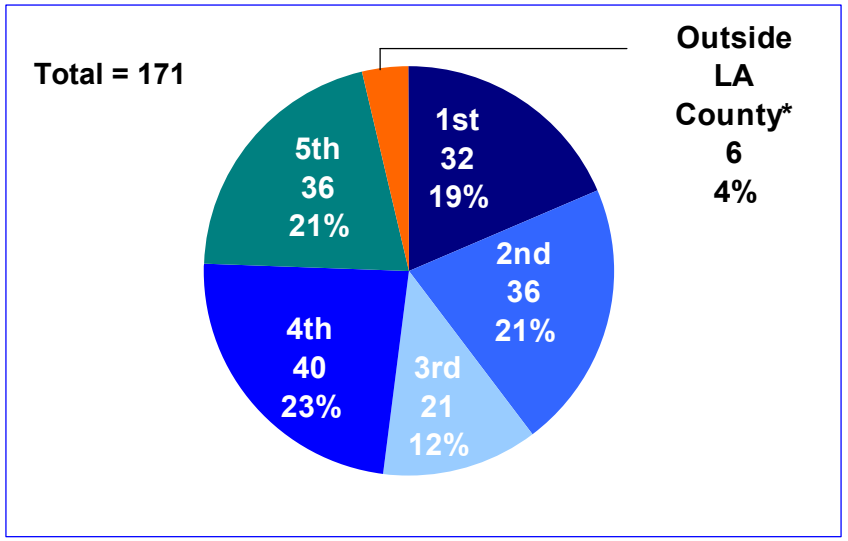
Note: Ethnicities are based on what was entered into CWS/CMS. Data for ethnicity and race may be inconsistent due to the subjective views of Children's Social Workers entering the information into CWS/CMS.

Comparative View
2011 vs. 2012 Child Deaths Reported to DCFS by Supervisorial District

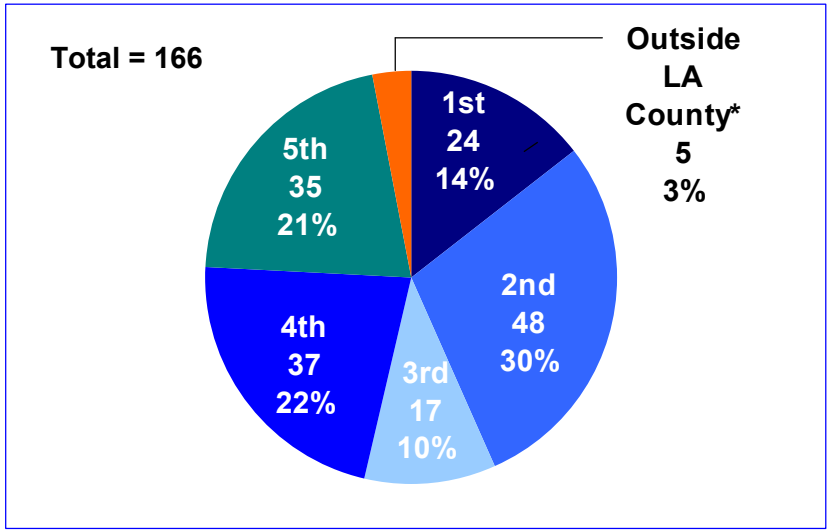
CY 2011 Supervisorial District of Incident (Without DCFS History)



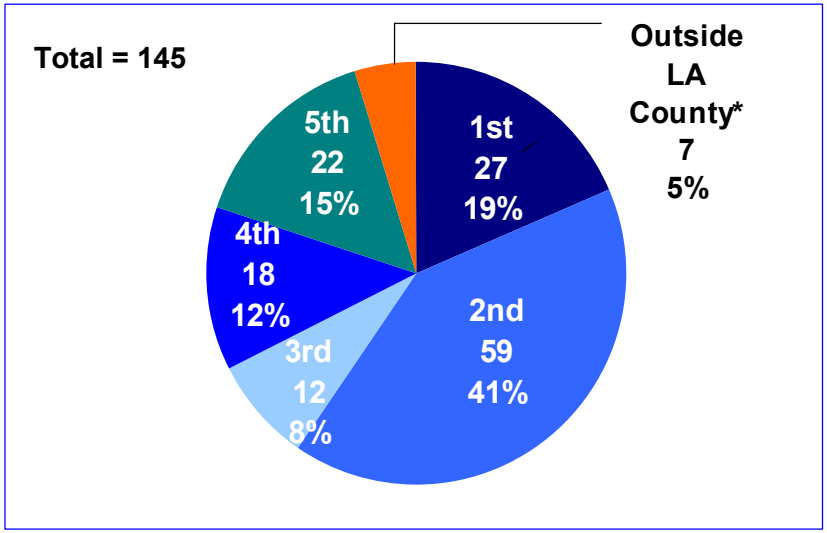
CY 2012 Supervisorial District of Incident (Without DCFS History)



CY 2011 Supervisorial District of Incident (With DCFS History)



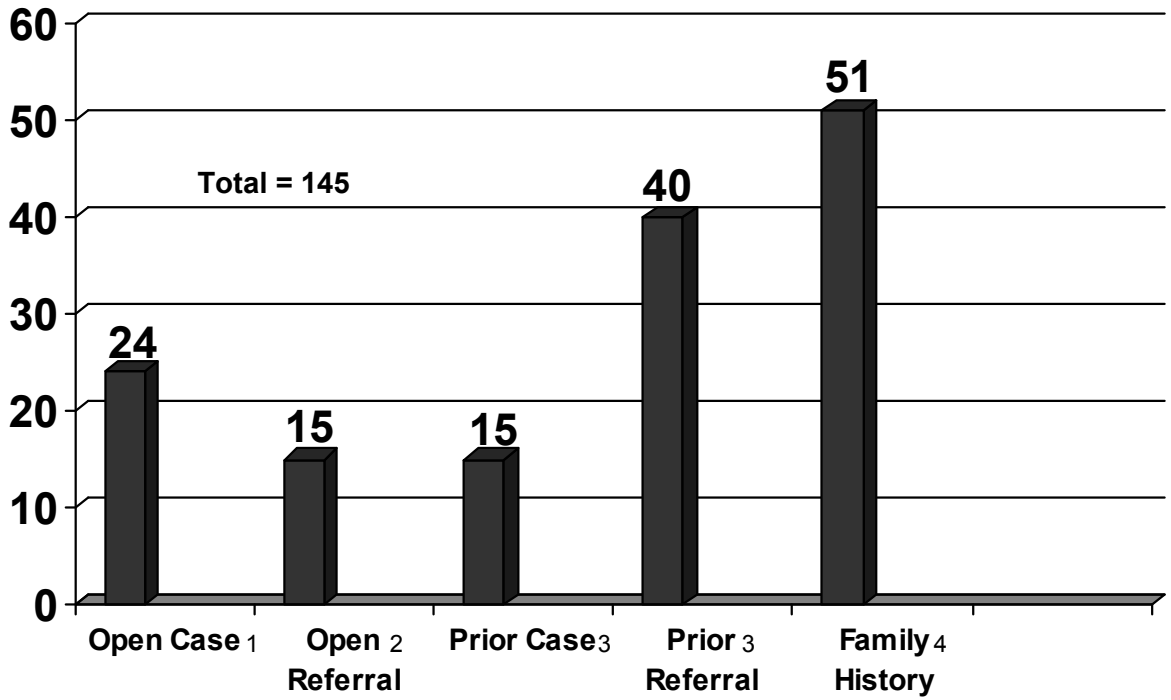
CY 2012 Supervisorial District of Incident (With DCFS History)



*Indicates a death of a child who was an LA County resident at the time of death but whose incident occurred outside LA County.

DCFS Status at Time of Death
2012 Deaths Reported to DCFS

DCFS status at time of death is prioritized in the following order: 1) Open Case 2) Open Referral 3) Closed Case 4) Closed Referral and 5) Family History, for example, if a child has an open case at time of death, closed referral two years earlier, and a sibling with an open case then the child is only included in the Open Case category.



[1]Only includes those cases that were open prior to the child's death. It does not include cases that were opened due to an incident/injury that lead to the child's death.

[2]Includes all open referrals regardless of the number of days open. It does not include referrals that were opened due to an incident/injury that lead to the child's death.

[3]There is no specified time frame established for including a child with a closed case or closed referral (e.g., a child with a closed referral seven years ago is still included in this category). The state's practice is to review history going back five years.

[4]These children do not have DCFS history themselves, but have a family member who had history with DCFS.

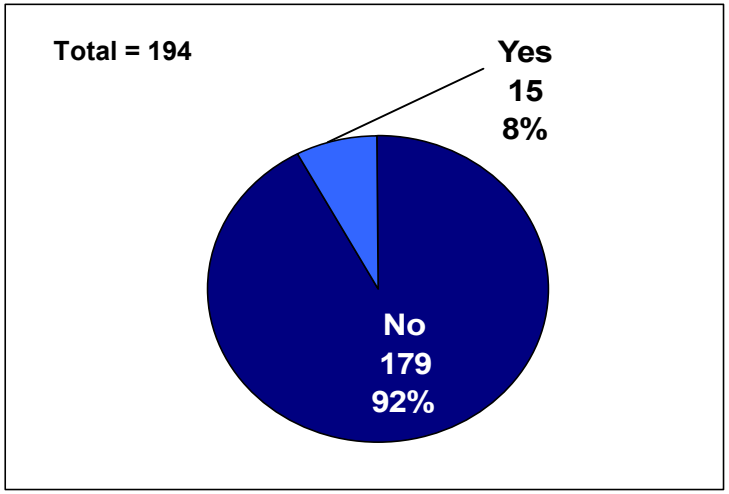
2012 - Summary of Data Findings for 94 Cases with an Open Case, Open Referral, Prior Case, Prior Referral Related to the Deceased Child at Time of Death

- **Open Case: 24**
  - Age**- 0-1:** 10, **12-17:** 6, **4-11:** 5, **2-3:** 2, **18-21:** 1
  - Supervisorial District- 2nd : 12, 1st : 4, 3rd : 2, 4th : 2, 5th : 2, Outside LA County: 2
  - Mode of Death- Pending: 10, Not a Coroner Case: 8, Accidental: 3, Natural: 1, Homicide: 1, Undetermined 1
  - Captured Trend- Medical/Natural: 12, Accidental Injury: 2, Physical Abuse: 2, Vehicular Related: 2, Co-sleeping: 1, Gestational: 1, Maternal Substance Use: 1, Neglect: 1, Suicide: 1, Third Party Homicide: 1
  - Perpetrator- None: 16, Mother: 4, Mother and Father: 3, Unknown: 1
- **Open Referral: 15**
  - Age- **0-1:** 8, **12-17:** 4, **2-3:** 2, **4-11:** 1
  - Supervisorial District- 2nd : 5, 5th: 4, 4th: 3, 1st : 2, 3rd : 1
  - Mode of Death- Not a Coroner Case: 6, Pending: 5, Accidental: 3, Undetermined 1
  - Captured Trend- Medical/Natural: 4, Maternal Substance Abuse: 3, Gestational: 2, Vehicular Related: 2, Accidental Overdose: 1, Gang Related: 1, Physical Abuse: 1, Unsafe Sleeping Environment: 1
  - Perpetrator- Mother: 6, None: 6, Unknown: 2, Mother and Father: 1
- **Prior Case: 15**
  - Age- **4-11:** 7, **12-17:** 7, **2-3:** 1
  - Supervisorial District- 2nd : 9, 4th: 4, 5th: 1, Outside LA County: 1
  - Mode of Death- Pending: 10, Accidental: 2, Homicide: 2, Suicide: 1
  - Captured Trend- Medical Natural: 5, Gang Related: 3, Suicide: 2, Vehicular Related: 2, Accidental Injury: 1, Hanging: 1, Third Party Homicide: 1
  - Perpetrator- None: 9, Unknown 4, Mother: 1, Non-Relative: 1
- **Prior Referral: 40**
  - Age- **12-17:** 28, **4-11** 6, **2-3**: 3, **0-1:** 3
  - Supervisorial District- 2nd : 13, 1st : 10, 5th: 9, 3rd : 4, 4th: 4
  - Mode of Death- Pending: 28, Accidental: 3, Homicide: 3, Suicide: 3, Undetermined: 2, Natural: 1
  - Captured Trend- Gang Related: 7, Medical/Natural: 6, Suicide: 4, Third Party Homicide: 4, Vehicular Related: 4, Accidental Injury: 4, Drowning: 2, Hanging: 2, Accidental Overdose: 1, Co-sleeping: 1, Fire: 1, Neglect: 1, Physical Abuse: 1, Self Inflicted Gunshot Wound: 1, Unsafe Sleeping Environment: 1
  - Perpetrator- None: 21, Unknown: 13, Mother and Father: 3, Non-Relative: 2, Mother: 1

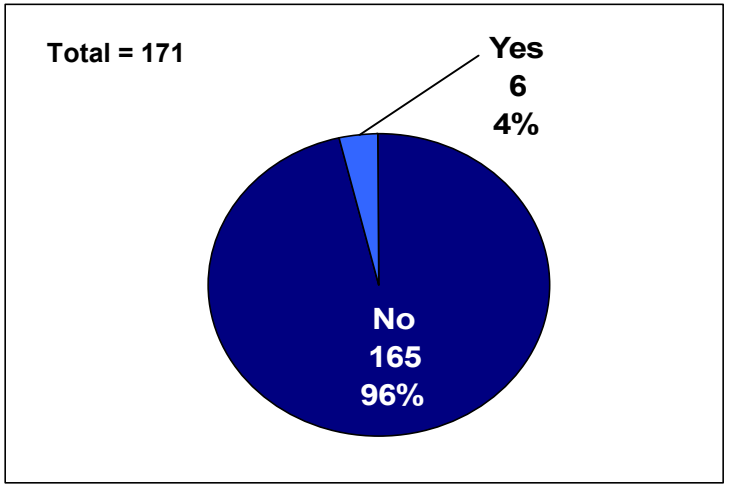
Minor Parent(s) at Time of Birth 2011 vs. 2012

Indicates whether one or both parents were under 18 years of age at the time of the child's birth

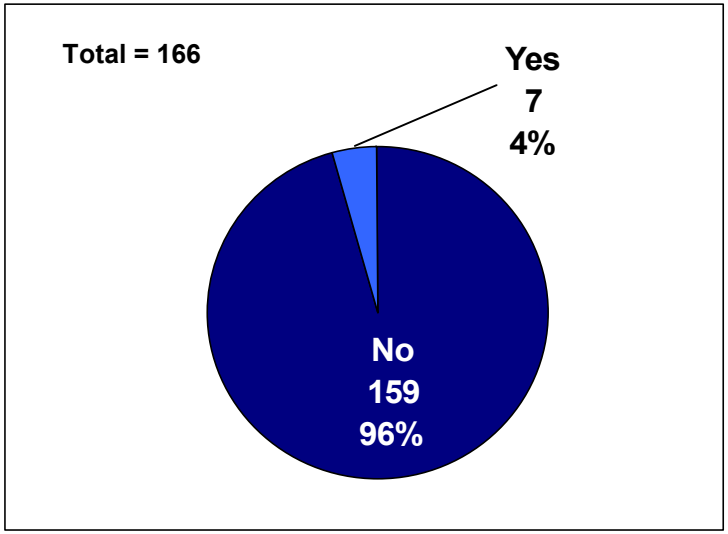
2011 Child Deaths (Without DCFS History)



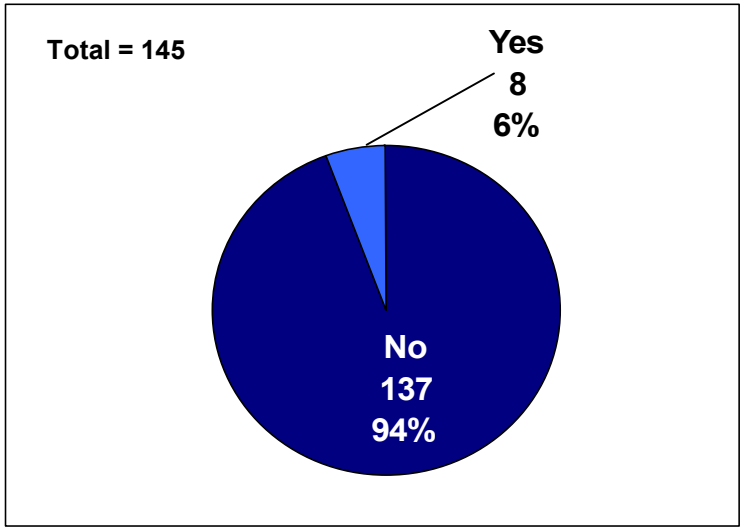
2012 Child Deaths (Without DCFS History)



2011 Child Deaths (With DCFS History)



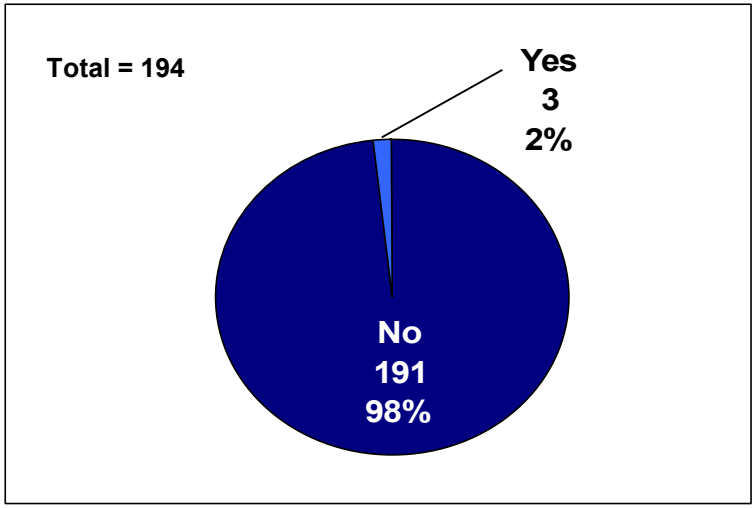
2012 Child Deaths (With DCFS History)



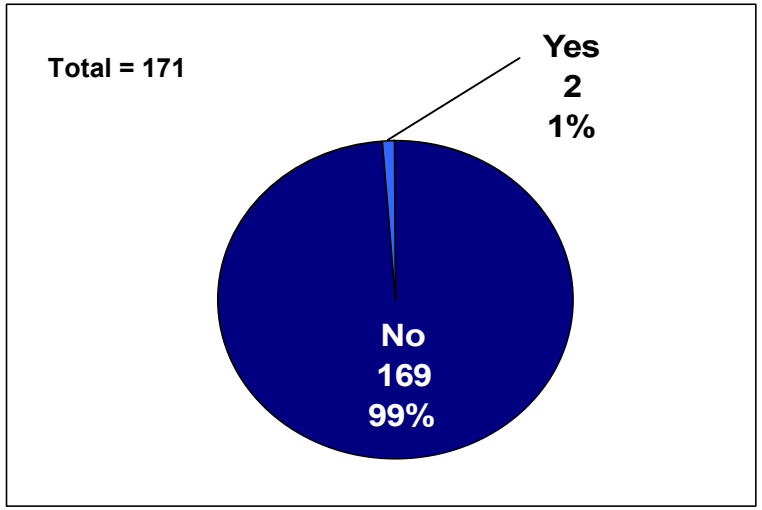
Minor Parent(s) at Time of Death Reported to DCFS 2011 vs. 2012

Indicates whether one or both parents were under 18 years of age at the time of the child's date of death

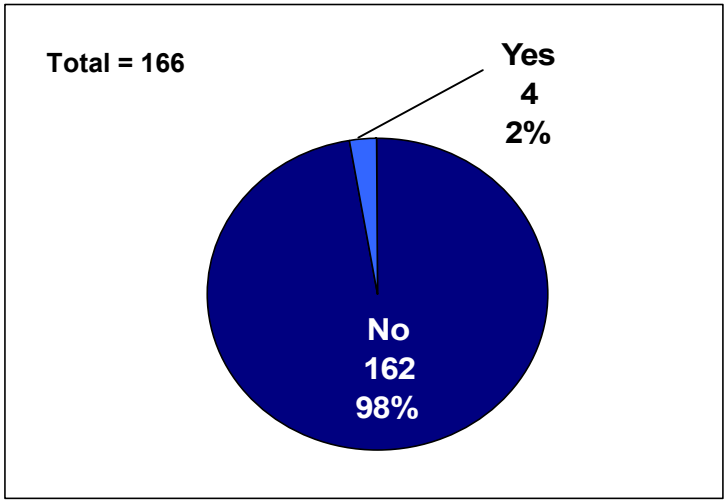
2011 Child Deaths (Without DCFS History)



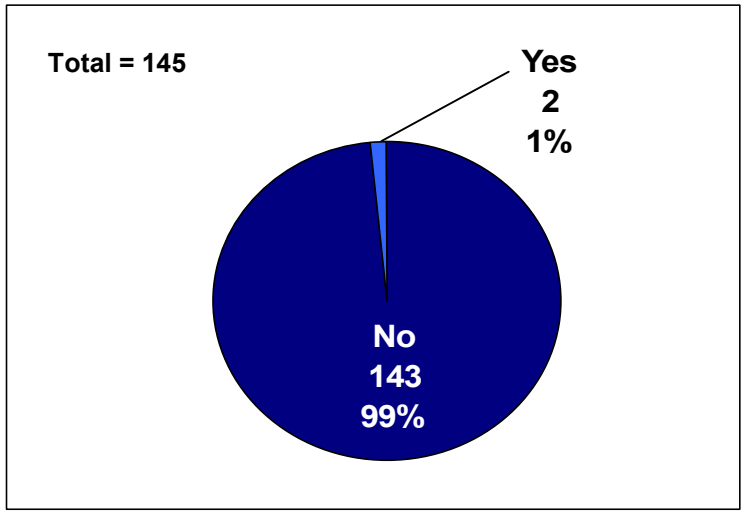
2012 Child Deaths (Without DCFS History)



2011 Child Deaths (With DCFS History)



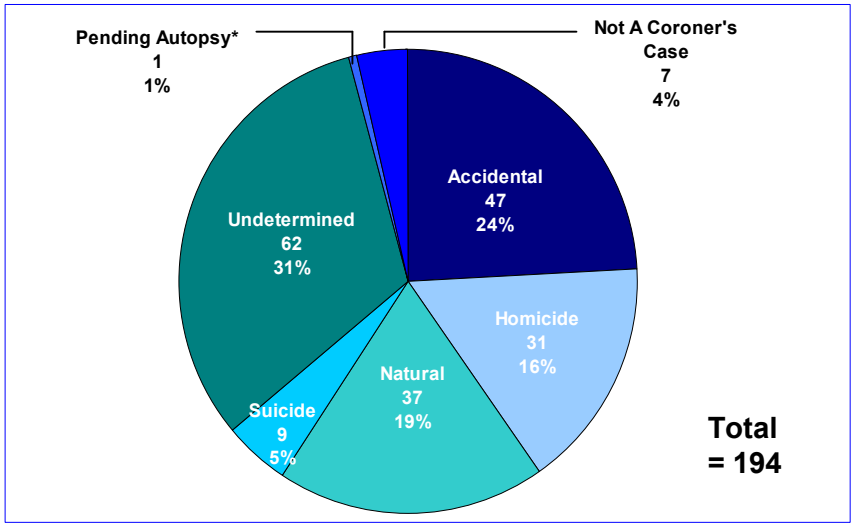
2012 Child Deaths (With DCFS History)



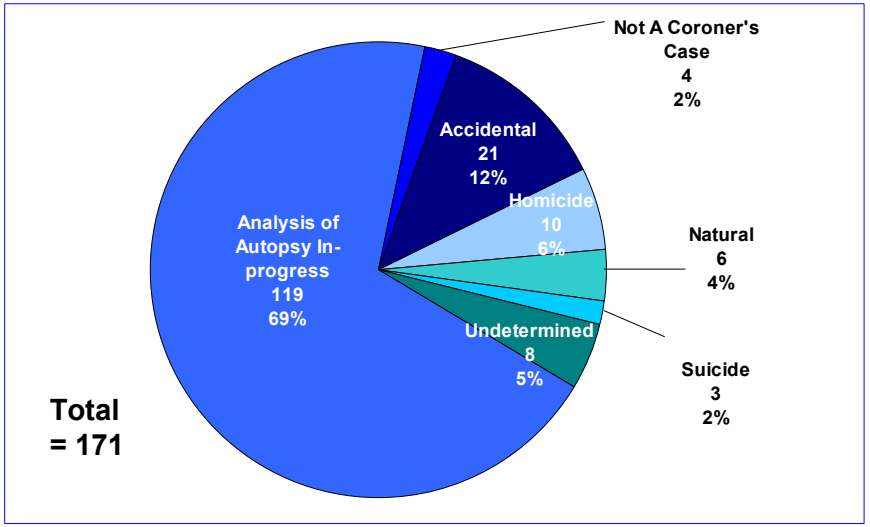
Comparative Analysis of Modes of Death, Captured Trends, Homicides for 2011 vs. 2012
Working Assumptions for ICAN and DCFS
Data Variances between ICAN and DCFS for 2011

Mode of Deaths 2011 vs. 2012

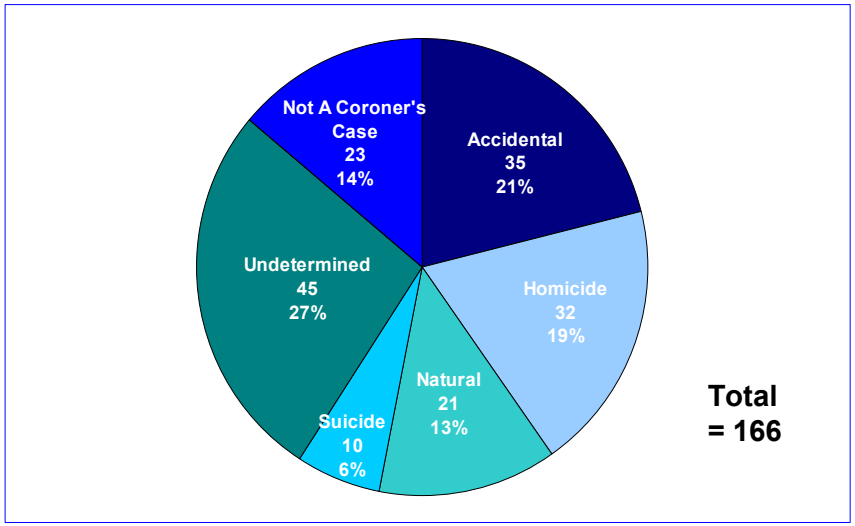
2011 Mode of Deaths (Without DCFS History)



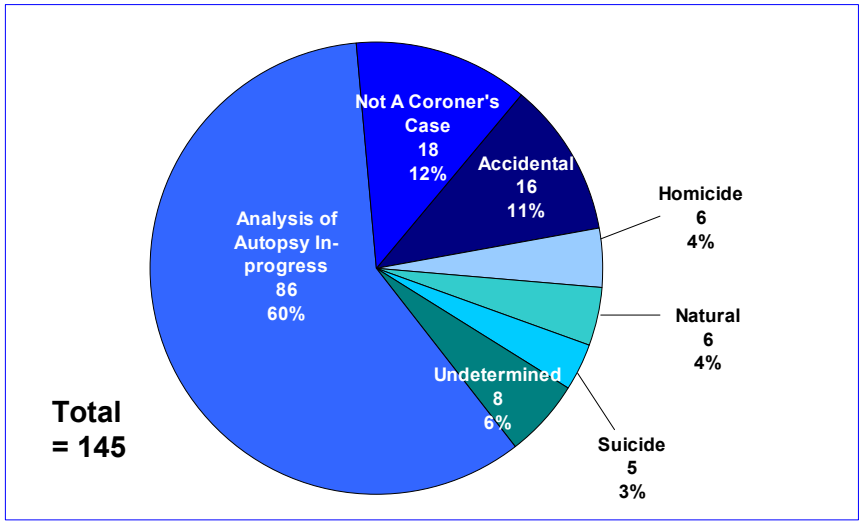
2012 Mode of Deaths (Without DCFS History)



2011 Mode of Deaths (With DCFS History)



2012 Mode of Deaths (With DCFS History)



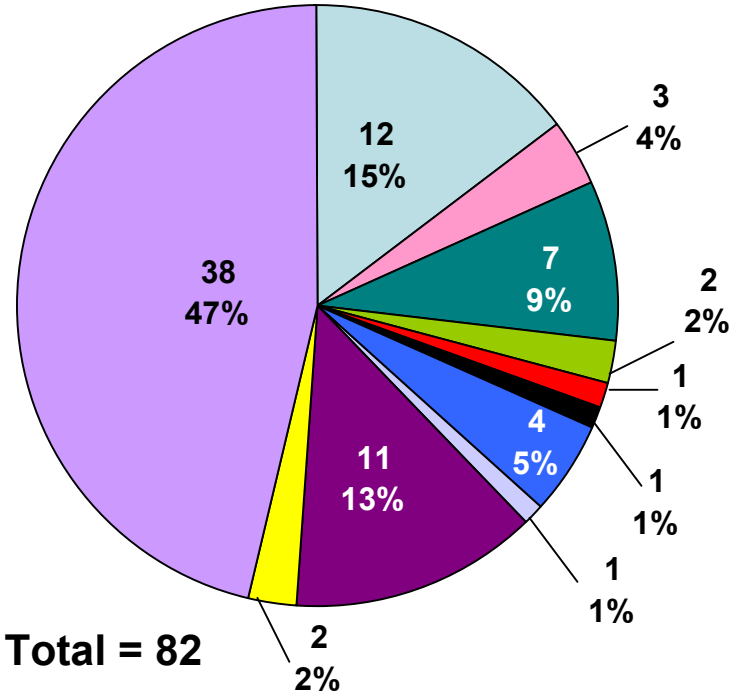
•One 2011 case is pending autopsy due to security hold by Law Enforcement

For Child Deaths, with and without DCFS History, the Final Mode of Death is Determined by the Coroner's Autopsy Report. The Coroner's standard modes-of-death are: Accidental, Homicide, Natural, Suicide and Undetermined. Cases that are not referred to the Coroner may consist of Natural deaths and the death certificate is signed by a physician. For ICAN Data (see page 33).

MODE: Accidental

Captured Trends Based on Fatality Circumstances

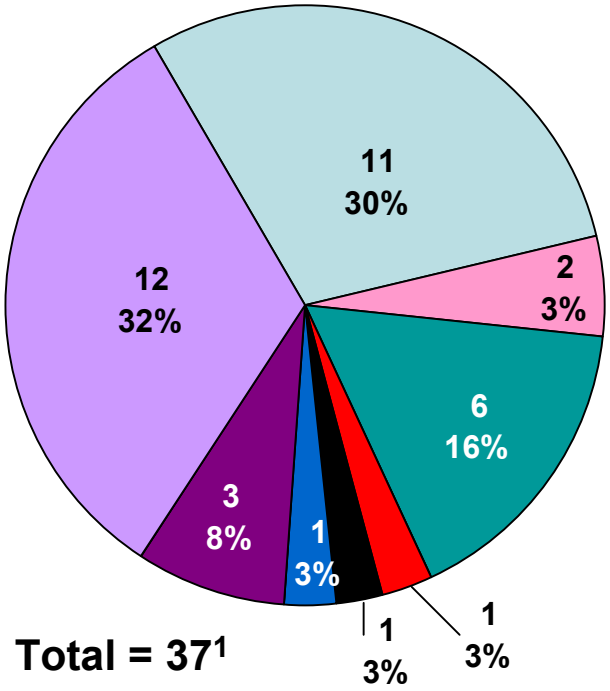
2011 Final Trend



Total = 82

2012 Final Trend

(Analysis of 205 autopsies in progress)



Total = 37[1]

- Injury*
- Overdose
- Drowning
- Fire
- Gestational*
- Maternal Substance Abuse
- Medical/Natural*
- Neglect*
- Stillborn*
- Unsafe Sleeping Environment
- Vehicular Related

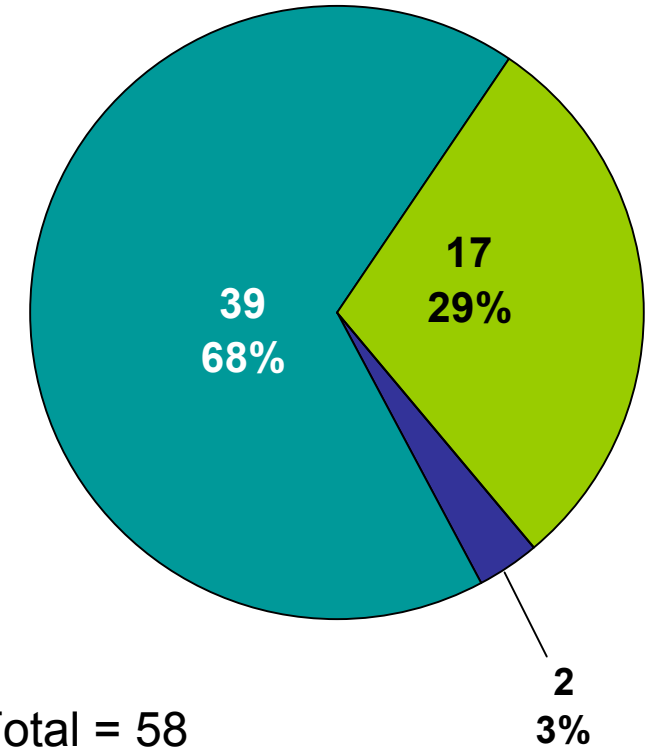
***Injury:** Accidents involving bicycles, skateboards, televisions, and choking accidents. **Gestational:** Unknown if mother took something to abort the fetus. **Neglect:** falling out of window. **Stillborn:** Includes mother's medical condition and any accidents mother has while pregnant and fetus delivered stillborn.

[1]For 2012, there is one preliminary captured trend under Accidental Injury which is awaiting final autopsy results and one accidental overdose that is not a Coroner's case.

MODE: Natural

Captured Trends Based on Fatality Circumstances

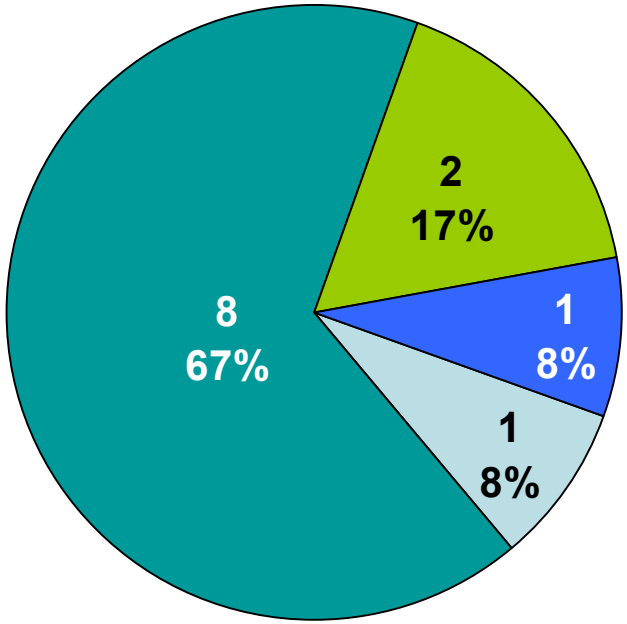
2011 Final Trend



Total = 58

2012 Final Trend

(Analysis of 205 autopsies in progress)



Total = 12[1]

- Accidental Injury*
- Gestational
- Medical/Natural
- Stillborn
- Sudden Unexplained Infant Death

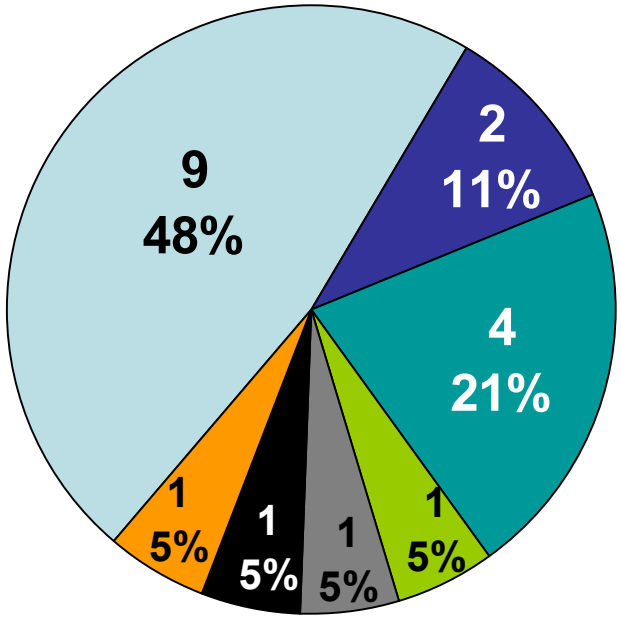
* **Accidental Injury:** The child was medically fragile and placed in medical facility and the feeding tube accidentally became dislodged.

[1]For 2012 there is one preliminary captured trend of Sudden Unexplained Infant Death which is awaiting final autopsy results.

MODE: Suicide

Captured Trends Based on Fatality Circumstances

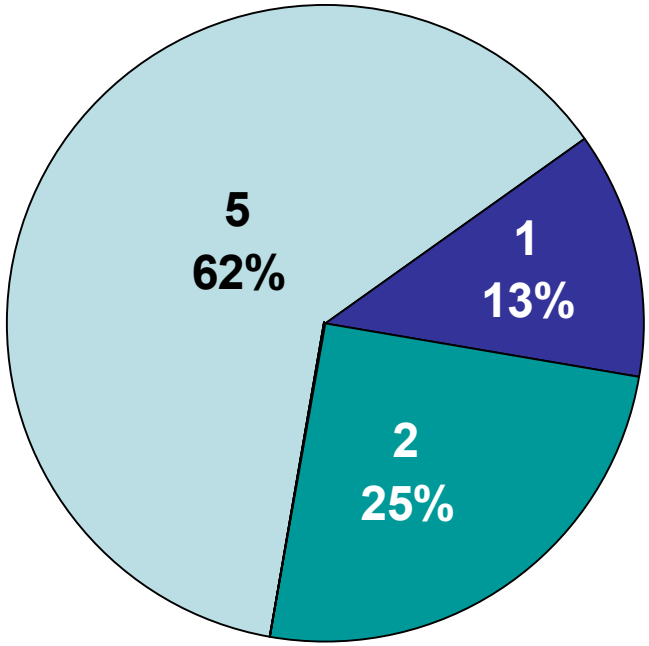
2011 Final Trend



Total = 19

2012 Final Trend

(Analysis of 205 autopsies in progress)

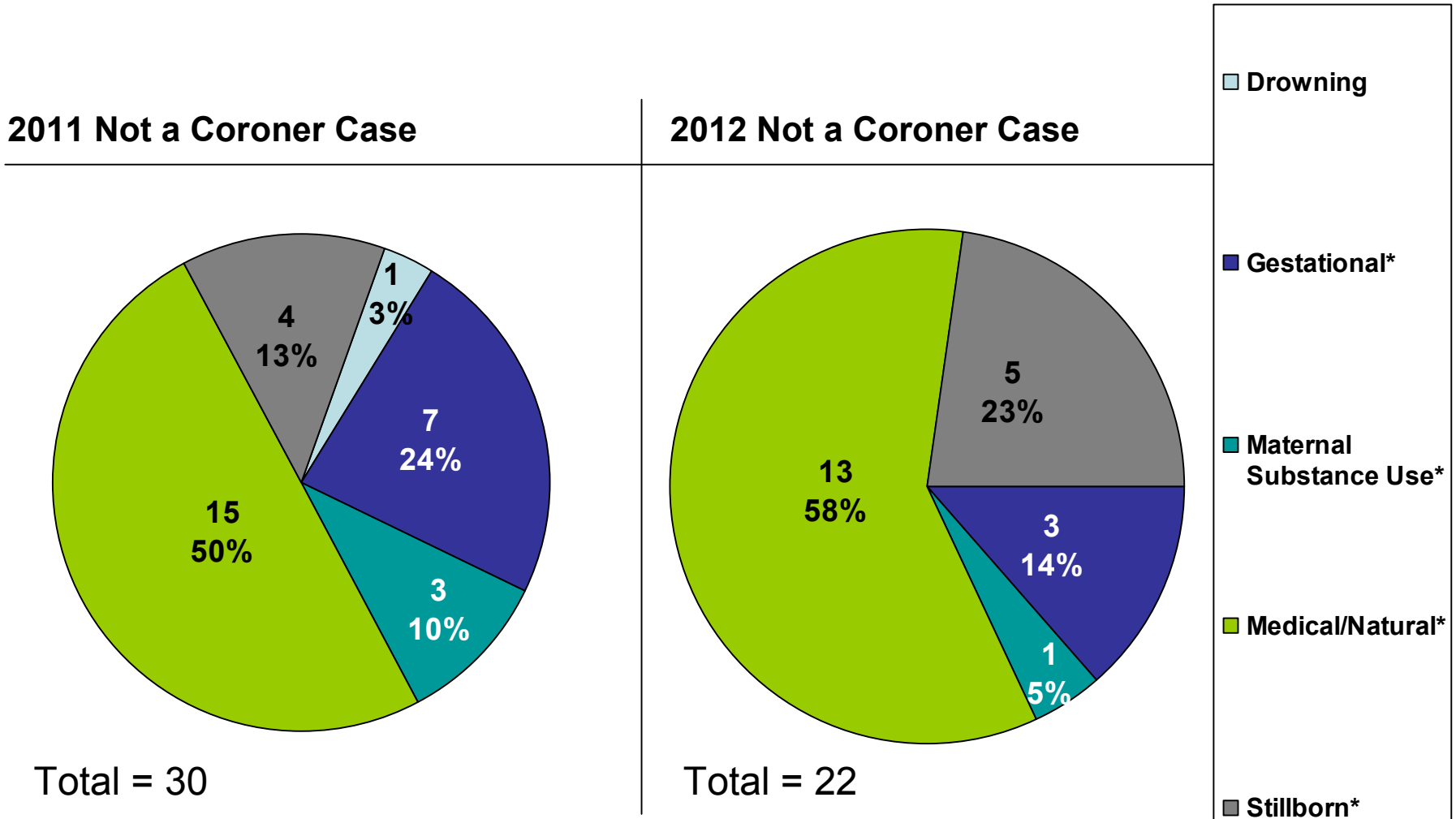


Total = 8

- Hanging
- Jumped from Building
- Self Inflicted gunshot wound
- Intentional vehicular crash
- Jumped in front of train
- Overdose
- Jumped in front of vehicle

Not a Coroner Case

Captured Trends Based on Fatality Circumstances



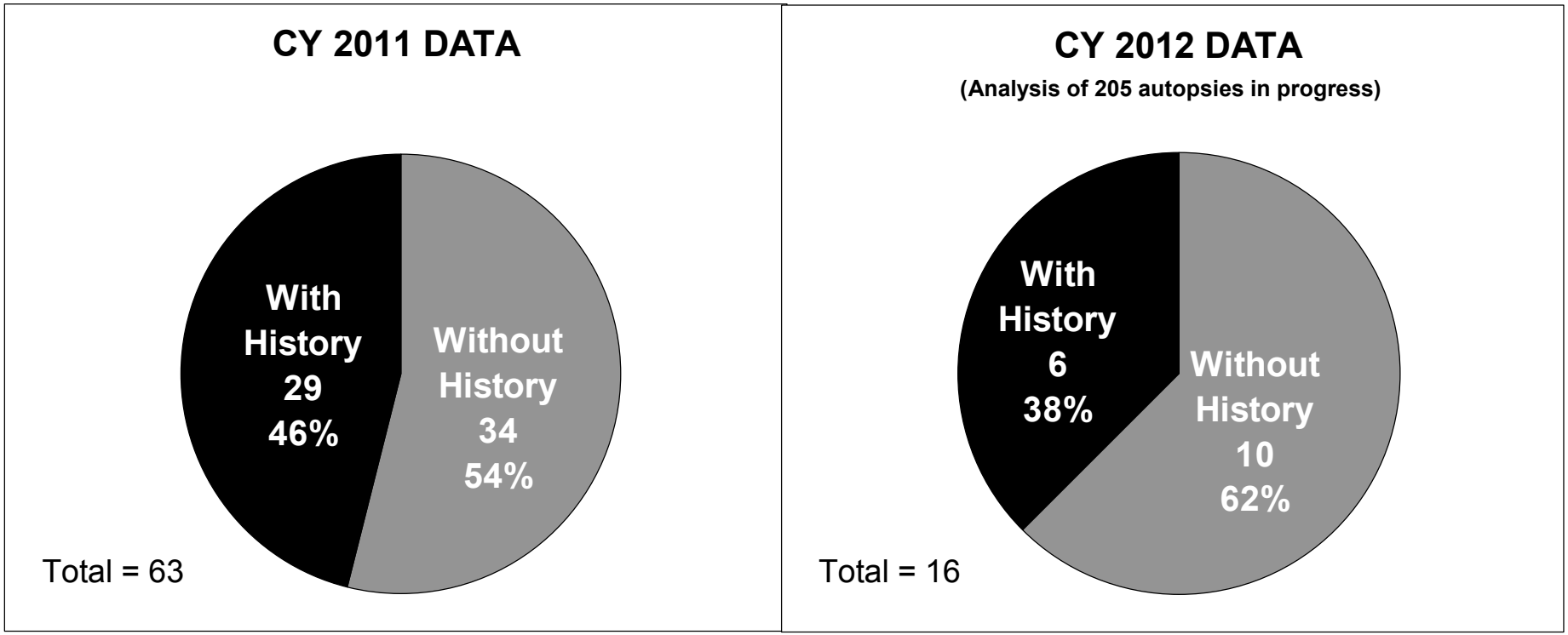
***Gestational**: Complications in utero which subsequently lead to the child's death. **Maternal Substance Use:** Mother used drugs during pregnancy unknown if drug use lead to child's death. **Medical Natural:** Child died of natural causes, physician signed death certificate. **Stillborn:** Child delivered without signs of life, physician signed death certificate.

Summary of Data Findings for 2011 and 2012 Deaths Classified as Homicide

2011 – 63 Homicides
▪29 of the 63 (46%) homicides had DCFS History. ▪25 of the homicides met SB39 subdivision A & C criteria indicating the child's death was a result of parent/caregiver abuse/neglect. ▪10 of the 25 (40%) had DCFS History and were open.
Of the 63 Homicides: Race/Ethnicity: Hispanic/Latino 47 (75%), African-American 13 (21%), and White 3 (5%) Gender: Male 48 (76%) and Female 15 (24%) Age: **12-17**: 36 (57%), **0-1**: 20 (32%), **2-3**: 5 (8%), **4-11**: 2 (3%)
26 (41%) were by a parent, relative, or caregiver: Father 8 (13%), Mother & Father 8 (13%), Mother's Boyfriend 5 (8%), Mother 4 (6%), and Mother & Step-Father 1 (2%)
37 of the 63 (59%) homicides were identified as "Third Party Homicides" with the identified perpetrator as: Unknown 34 (54%), Non-relative 2 (3%), and None 1 (2%). 29 (78%) "Third Party Homicides" were gang related.

2012 – 16 Homicides (Analysis of 205 autopsies in progress)
6 of the 16 (38%) Homicides had DCFS History. We continue to review and analyze Coroner and Law Enforcement records.
Of the 16 Homicides: Race/Ethnicity: Hispanic/Latino 10 (63%), African American 4 (25%), and White 2 (13%) Gender: Male 12 (75%) and Female 4 (25%) Age: **12-17**: 12 (75%), **0-1**: 3 (19%), **4-11**: 1 (6%), **2-3**: 0 (0%)
3 (19%) were by a parent, relative, or caregiver: Mother 2 (67%), Mother's Boyfriend 1 (33%)
13 (81%) homicides were identified as "Third Party Homicides" with the identified perpetrator as: Unknown 12 (75%), and None 1 (6%). 10 (63%) "Third Party Homicides" were gang related.

Comparative View
Homicide
With and Without History



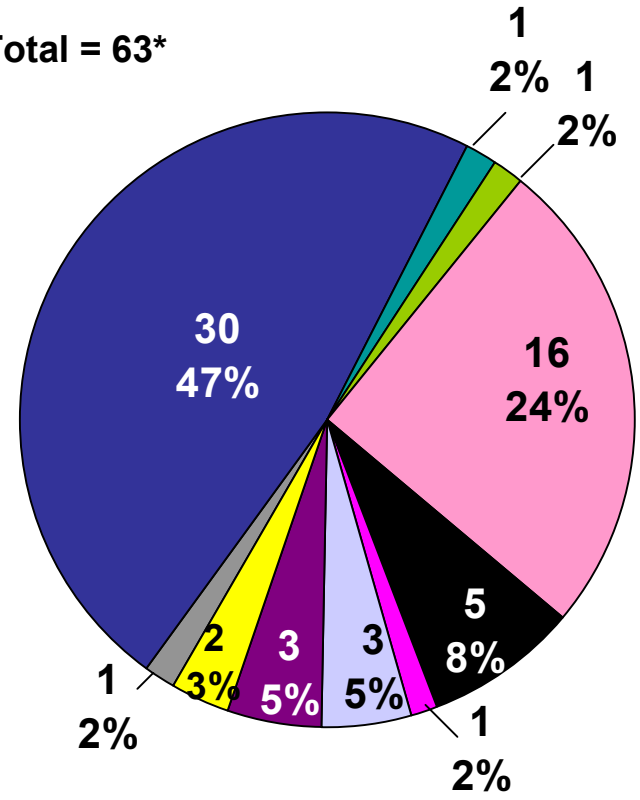
2011: The October 1, 2012 report indicates 55 homicides. Six 2011 homicides were added based on information received by Coroner on October 10, 2012. Two additional homicides were added based on law enforcement findings.

Homicide

Captured Trends Based on Fatality Circumstances

2011 Final Trend

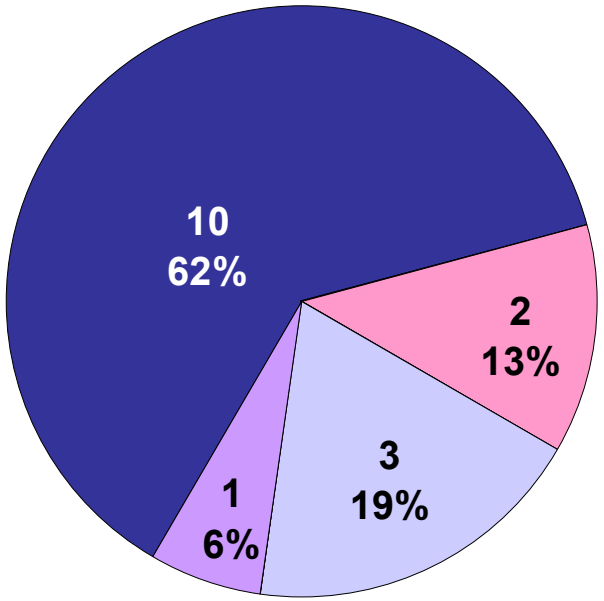
Total = 63*



2012 Final Trend

(Analysis of 205 autopsies in progress)

Total = 16



- Accidental Injury
- Gang Related
- Neglect
- Other
- Physical Abuse
- Shaken Baby Syndrom
- Stillborn
- Third Party Shooting
- Murder Suicide
- Officer Involved Shooting
- Drowning

Accidental Injury: Accidental shooting that was ruled a homicide.

Other: Asphyxia (intentional suffocation)

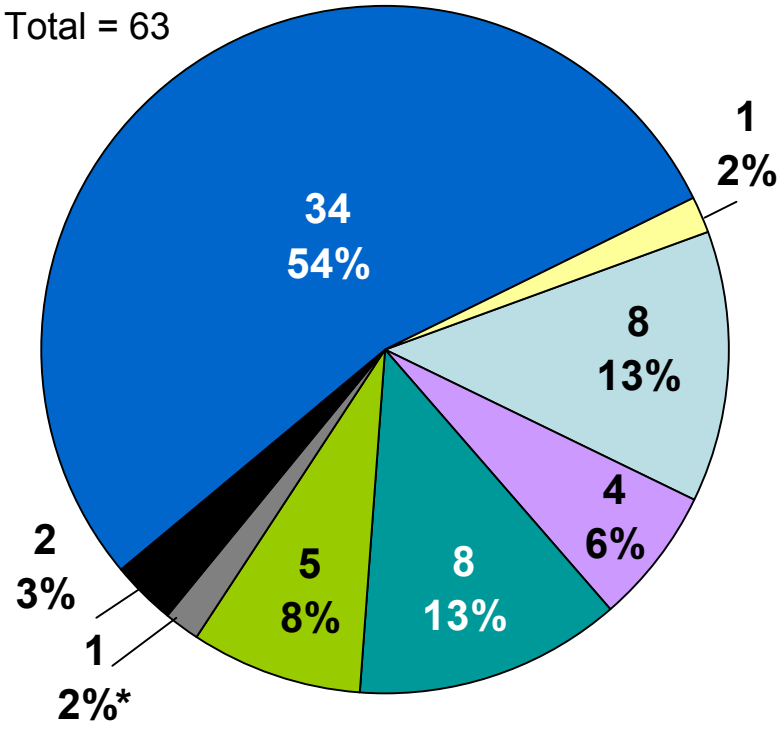
Stillborn: Mother disregarded doctor's advice to deliver baby that was medically fragile. Child subsequently died and stillborn death was ruled a homicide.

*For 2011 there is a preliminary captured trend of Third Party Shooting, which is awaiting final autopsy results.

Homicides by Perpetrator Type

2011 Perpetrator Data

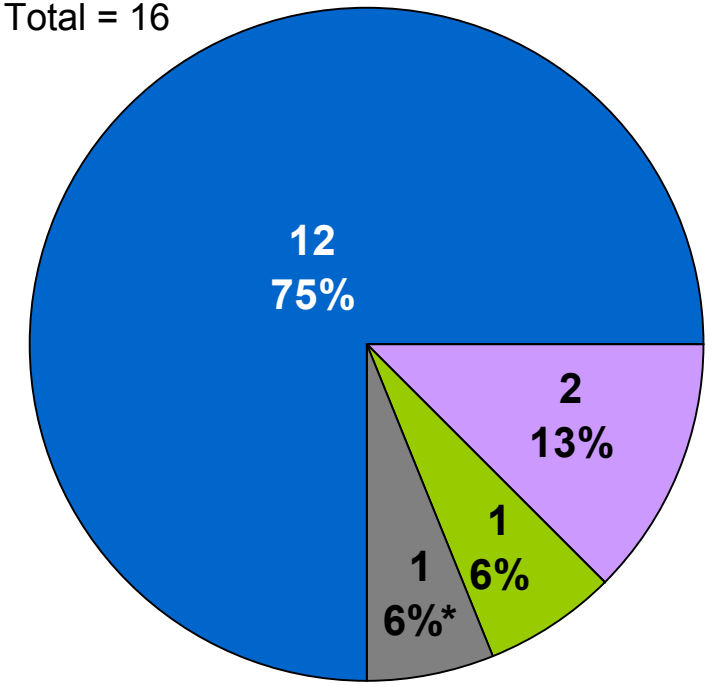
Total = 63



2012 Perpetrator Data

(Analysis of 205 autopsies in progress)

Total = 16



- Father
- Mother**
- Mother & Father
- Mother's Boyfriend
- None*
- Non-Relative
- Unknown
- Mother & Step-Father

2011- None*, Non-Relative, and Unknown categories represent 37 of the 63 "Third Party Homicides"
-25 Homicides were determined to meet SB39 A & C criteria indicating that the child's death was a result of parent/caregiver abuse/neglect.
**One homicide by caregiver (mother) did not meet SB39 criteria because the child was delivered stillborn.

2012- Unknown and None* categories represent 3 of the 16 "Third Party Homicides"
-Further Analysis is required on those homicides that meet SB39 criteria based on the ruling in *Butterfield vs. Lightbourne*

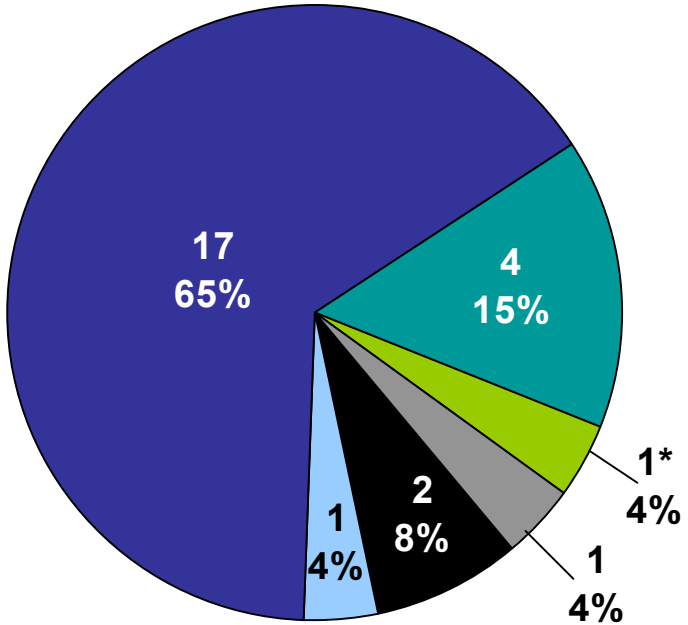
NONE*- One death in 2011 was an officer involved shooting, the 2012 death was a result of a breaking and entering where homeowner shot child.

Note: There were no homicides by Foster Parent.

Homicide by Caregiver

Captured Trends Based on Fatality Circumstances

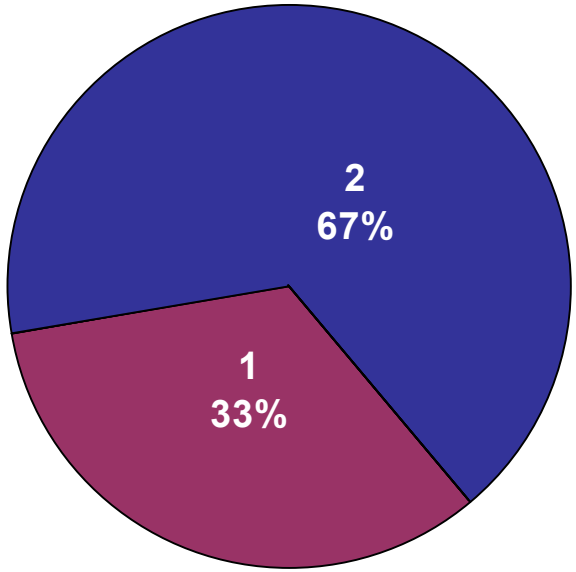
2011



Total = 26

2012

(Analysis of 205 autopsies in progress)



Total = 3

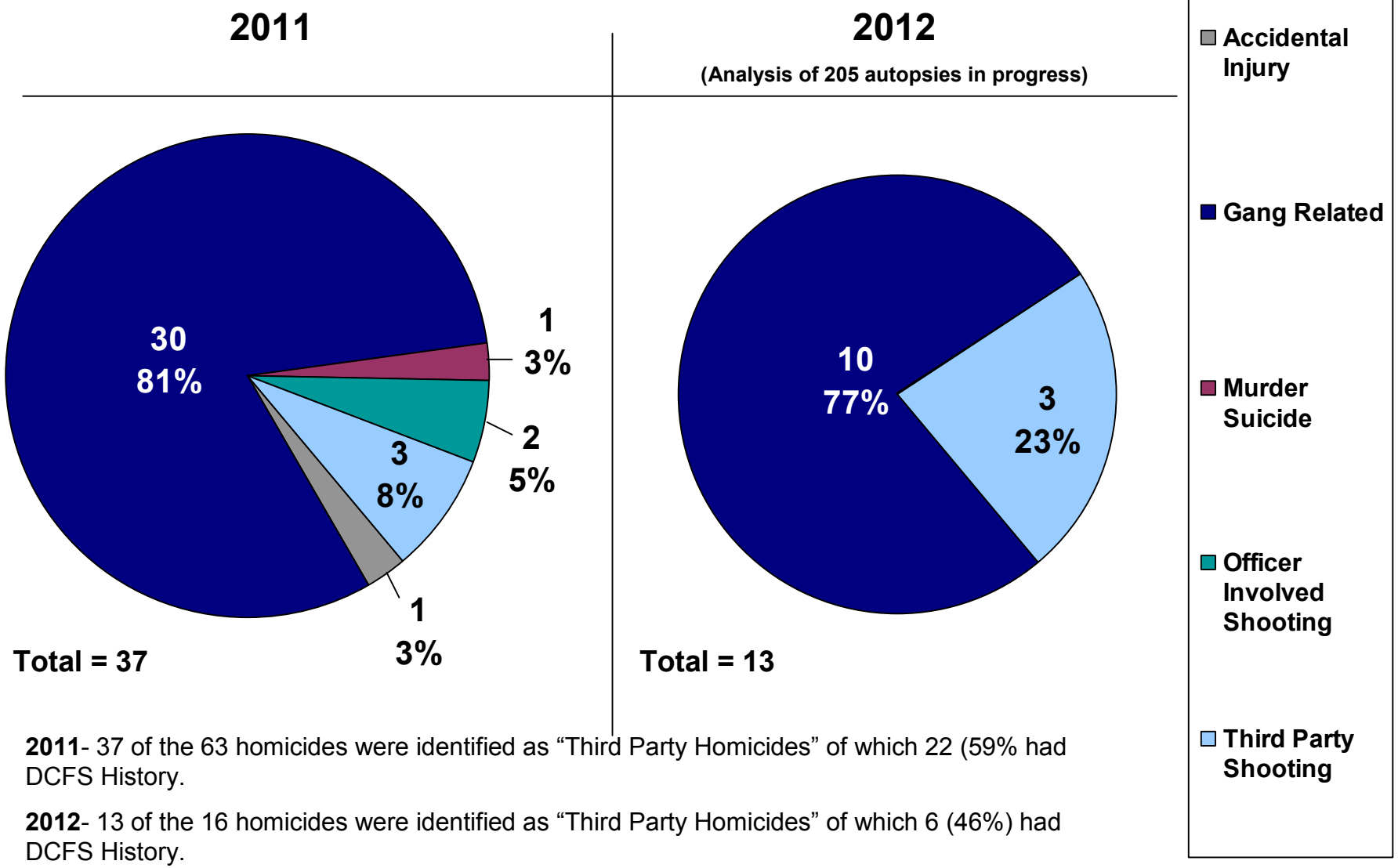
Ten of the 26 (38%) deaths had DCFS History of which 8 (80%) were from Physical Abuse and 2 (20%) were from Shaken Baby Syndrome.

*One Stillborn death was ruled a Homicide

In 2012, none had DCFS History.

Homicide by "Third Party"

Captured Trends Based on Fatality Circumstances



2011- 37 of the 63 homicides were identified as "Third Party Homicides" of which 22 (59% had DCFS History.

2012- 13 of the 16 homicides were identified as "Third Party Homicides" of which 6 (46%) had DCFS History.

Working Assumptions for DCFS and ICAN

In ICAN's "Child Death Review Team Report 2012" – 'Report compiled from 2011 Data', they report 276 child fatalities for 2011 in comparison with DCFS data of 360 child fatalities in 2011. The difference (84) is due to reporting methodology.

- ICAN analyzes child fatalities that are reported to DCFS and for which the autopsy is conducted by Los Angeles County Coroner. ICAN does not track child deaths that occur outside LA County even if there is an open case, open referral, or DCFS history if the LA County Coroner is not conducting the autopsy.
- DCFS reports on all child fatalities that were reported to the Child Protection Hotline and includes child deaths where the incident occurs outside LA County if there is an open DCFS referral and/or case. Also, DCFS analyzes child deaths that occur within LA County even though their residence is outside LA County.
- ICAN tracks child fatalities where the Coroner determines the mode as Accidental, Suicide, Homicide, and Undetermined. They do not track Natural Modes and deaths that do not become a Coroner's case.
- DCFS includes deaths that are Accidental, Suicide, Homicide, Undetermined, Natural and Not a Coroner's Case but reported to the Child Protection Hotline.

Data Variances from Senate Bill 39 (SB39) and ICAN for 2011

***Variances are illustrated for year 2011 as ICAN's Data Collection for 2012 has not begun.**

ICAN	
DEATH MODE	**TOTAL DEATHS**
Accidental	88[1]
Homicide	61[2]
Natural*	0[3]
Suicide	19
Undetermined	108[4]
Pending	0[5]
Not a Coroner Case	0[6]
Total	276

SB39	
DEATH MODE	**TOTAL DEATHS**
Accidental	82[1]
Homicide	63[2]
Natural	58[3]
Suicide	19
Undetermined	107[4]
Pending	1[5]
Not a Coroner Case	30[6]
Total	360

1**Accidental:** Of ICAN's 88 deaths, they have included 12 deaths that were not reported to the Child Protection Hotline. These deaths were reported to ICAN via the Coroner. DCFS is accounting for 3 additional accidental deaths that were reported to the Hotline but did not have a LA County Coroner Investigation and were not accounted for by ICAN. There is an overlap of deaths reported by ICAN and DCFS.

2**Homicide:** ICAN is reporting 61 Homicides vs. DCFS who is reporting 63 homicides, two of which occurred outside LA County but had an open DCFS case/referral.

3**Natural:** ICAN does not track Natural deaths.

4**Undetermined:** Of ICAN's 108 deaths, they have included 7 deaths that were reported to ICAN by the Coroner but not to DCFS. DCFS is accounting for 3 additional undetermined deaths that did not meet ICAN criteria for tracking and analysis. Hence a data variance.

5**Pending:** ICAN has zero pending cases and DCFS has 1 case pending due to a security hold placed on the autopsy report by Law Enforcement.

6**Not a Coroner Case:** ICAN does not track "Not a Coroner Case".